JOINT BUDGET COMMITTEE

STAFF FIGURE SETTING
FY 2018-19

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, and Other Medical Programs)

JBC WORKING DOCUMENT - SUBJECT TO CHANGE
STAFF RECOMMENDATION DOES NOT REPRESENT COMMITTEE DECISION

PREPARED BY:
ERIC KURTZ, JBC STAFF
MARCH 5, 2018

JOINT BUDGET COMMITTEE STAFF
200 E. 14TH AVENUE, 3RD FLOOR • DENVER • COLORADO • 80203
TELEPHONE: (303) 866-2061 • TDD: (303) 866-3472
https://leg.colorado.gov/agencies/joint-budget-committee

CONTENTS

HOW TO USE THIS DOCUMENT

The Department Overview contains a table summarizing the staff recommended incremental changes followed by brief explanations of each incremental change. A similar overview table is provided for each division, but the description of incremental changes is not repeated, since it is available under the Department Overview. More details about the incremental changes are provided in the sections following the Department Overview and the division summary tables.

Decision items, both department-requested items and staff-initiated items, are discussed either in the Decision Items Affecting Multiple Divisions or at the beginning of the most relevant division. Within a section, decision items are listed in the requested priority order, if applicable.

DEPARTMENT OVERVIEW

The Department helps pay medical and long-term care expenses for low-income and vulnerable populations. To assist with these costs the Department receives significant federal matching funds, but must adhere to federal rules regarding program eligibility, benefits, and other features, as a condition of accepting the federal money. The major programs administered by the Department include:

- **Medicaid** – serves people with low income and people needing long-term care
- **Children's Basic Health Plan** – provides a low-cost insurance option for children and pregnant women with income slightly higher than the Medicaid eligibility criteria
- **Colorado Indigent Care Program** – defrays a portion of the costs to providers of uncompensated and under-compensated care for people with low income, if the provider agrees to program requirements for discounting charges to patients on a sliding scale based on income
- **Old Age Pension Health and Medical Program** – serves elderly people with low income who qualify for a state pension but do not qualify for Medicaid or Medicare.

The Department also performs functions related to improving the health care delivery system, including advising the General Assembly and the Governor, distributing tobacco tax funds through the Primary Care and Preventive Care Grant Program, financing Public School Health Services, and housing the Commission on Family Medicine Residency Training Programs.

SUMMARY OF STAFF RECOMMENDATIONS

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$8,689,783,801	$2,321,305,539	$1,187,217,735	$77,268,980	$5,103,991,547	417.7
HB 18-1161 (Supplemental Bill)	375,885,394	52,110,859	2,046,761	(202,310)	321,930,084	0.8
Other legislation	901,410	838,694	74,609	0	(11,893)	0.7
Long Bill supplemental add-on	(369,274,338)	(69,870,671)	(10,358,079)	425,041	(289,470,629)	0.0
TOTAL	**$8,697,296,267**	**$2,304,384,421**	**$1,178,981,026**	**$77,491,711**	**$5,136,439,109**	**419.2**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$8,697,296,267	$2,304,384,421	$1,178,981,026	$77,491,711	$5,136,439,109	419.2
R1 Medical Services Premiums	23,709,908	34,215,228	61,220,308	77,582	(71,803,210)	0.0
R3 Children's Basic Health Plan	7,490,833	(621,616)	1,034,180	0	7,078,269	0.0
R4 Medicare Modernization Act	6,915,992	6,915,992	0	0	0	0.0
R6 Home care visit verification	2,364,610	548,842	0	0	1,815,768	6.9
R7 Community transition services	241,942	120,971	0	0	120,971	0.0
R8 Medicaid savings initiatives	(819,702)	(1,891,328)	2,865,970	4,151	(1,798,495)	5.9
R9 Provider rates - Across-the-board	30,636,558	9,715,807	1,259,589	0	19,661,162	0.0
R9 Provider rates - Targeted	5,955,571	4,891,706	(274,539)	0	1,338,404	0.0
R10 Drug cost containment	132,777	(24,407)	(39,129)	0	196,313	0.0
R11 Administrative contracts	1,539,236	1,162,564	831,237	0	(454,565)	0.0
R12 Children's habilitation transfer	278,395	139,200	0	0	139,195	1.8
R13 All-payer claims database	(500,000)	(500,000)	0	0	0	0.0
R14 Safety net programs	749,728	0	749,728	0	0	0.0
R15 CHASE administration	761,794	0	380,898	0	380,896	5.4
R16 Emergency transport CPE	18,627,725	(710,560)	9,547,069	0	9,791,216	0.0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
R17 Single assessment tool	(5,139,275)	(2,458,043)	0	0	(2,681,232)	0.0
R18 Cost allocation	366,400	120,050	63,150	0	183,200	0.0
R19 IDD waiver consolidation	478,500	239,250	0	0	239,250	0.0
BA11 County administration	0	0	0	0	0	0.0
BA12 Public school health services	5,045,159	0	2,590,298	0	2,454,861	0.0
BA14 Benefits utilization system	230,040	115,020	0	0	115,020	0.0
NP Family medicine residencies	600,000	300,000	0	0	300,000	0.0
NP CBMS-PEAK	467,661	500,178	(267,342)	1,501	233,324	0.0
NP Risk management cybersecurity	3,766	1,883	0	0	1,883	0.0
NP OIT HCPF security	(84,054)	(23,184)	(18,843)	0	(42,027)	0.0
Staff initiated - veterans outreach	25,000	12,500	0	0	12,500	0.0
Centrally appropriated items	2,762,278	718,730	(3,470)	237,600	1,809,418	0.0
Transfers to other agencies	170,882	70,040	0	0	100,842	0.0
Annualize prior year budget actions	(69,636,861)	(13,395,204)	(2,850,863)	(19,010)	(53,371,784)	9.0
Other	(19,742)	0	(19,742)	0	0	0.0
TOTAL	**$8,730,651,388**	**$2,344,548,040**	**$1,256,049,525**	**$77,793,535**	**$5,052,260,288**	**448.2**
Proposed Legislation						
R7 Community Transition Services	(17,106,096)	(3,255,100)	(5,761,286)	0	(8,089,710)	0.0
R13 All-payer claims database	3,082,737	1,791,369	0	0	1,291,368	0.9
TOTAL	**$8,716,628,029**	**$2,343,084,309**	**$1,250,288,239**	**$77,793,535**	**$5,045,461,946**	**449.1**
INCREASE/(DECREASE)	**$19,331,762**	**$38,699,888**	**$71,307,213**	**$301,824**	**($90,977,163)**	**29.9**
Percentage Change	0.2%	1.7%	6.0%	0.4%	(1.8%)	7.1%
FY 2018-19 EXECUTIVE REQUEST	**$8,916,777,479**	**$2,377,554,130**	**$1,245,787,911**	**$77,457,371**	**$5,215,978,067**	**454.7**
Request Above/(Below) Recommendation	$200,149,450	$34,469,821	($4,500,328)	($336,164)	$170,516,121	5.6

DESCRIPTION OF INCREMENTAL CHANGES

FY 2017-18

LONG BILL SUPPLEMENTAL: Staff recommends a supplemental based on enrollment and utilization trends identified in the Department's February forecast. See the descriptions of *R1 Medical Services Premiums*, *R3 Children's Basic Health Plan*, and *R4 Medicare Modernization Act* for more information.

FY 2018-19

R1 Medical Services Premiums: Staff recommends an increase of $23.7 million total funds, including $34.2 million General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Medical Services Premiums line item.

R3 Children's Basic Health Plan: Staff recommends an increase of $7.5 million total funds, including a decrease of $621,616 General Fund, for projected changes in caseload, per capita expenditures, and fund sources for the Children's Basic Health Plan.

R4 Medicare Modernization Act: Staff recommends an increase of $6.9 million General Fund for the projected state obligation pursuant to the federal Medicare Modernization Act to pay the federal government in lieu of the state covering prescription drugs for people dually eligible for Medicaid and Medicare.

R6 HOME CARE VISIT VERIFICATION: Staff recommends an increase of $2.4 million total funds, including $548,842 General Fund, for implementing a federally required electronic system to track and verify the time that personal care and home health workers spend on home visits.

R7 COMMUNITY TRANSITION SERVICES: Staff recommends a net increase of $241,942 total funds, including $120,971 General Fund, for expanded counseling to people living in institutional settings about options for care in a community setting.

R8 Medicaid savings initiatives: Staff recommends a decrease of $819,702 total funds, including $1.9 million General Fund, for several initiatives designed to decrease Medicaid expenditures.

R9 provider rates: Staff recommends $6.0 million total funds, including $4.9 million General Fund, for targeted provider rate increases, and an additional across-the-board increase when the JBC decides on a common policy for community provider rates.

R9 Provider Rates - Targeted Increases				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Anesthesia Services	($9,728,911)	($2,950,535)	($274,539)	($6,503,837)
Alternative Care Facilities	15,684,482	7,842,241	0	7,842,241
Physician Services & Surgery Rebalancing	0	0	0	0
TOTAL - Targeted Increases	**$5,955,571**	**$4,891,706**	**($274,539)**	**$1,338,404**

R10 Drug cost containment: Staff recommends an increase of $132,777, but a decrease of $24,407 General Fund, for new prior authorization review requirements for physician administered drugs and exploration of alternative payment methods for the pharmacy benefit.

R11 Administrative contracts: Staff recommends $1.5 million total funds, including $1.2 million General Fund, to update funding for two administrative contracts and pay a federal disallowance.

R12 Children's habilitation transfer: Staff recommends $278,395 total funds, including $139,200 General Fund, to enhance and transfer the Children's Habilitation Residential Program (CHRP), which provides treatment and out of home services for foster children with intellectual and developmental disabilities, from the Department of Human Services to the Department of Health Care Policy and Financing.

R13 All-payer claims database: Staff recommends a decrease of $500,000 General Fund to remove funding for a scholarship program that lacks statutory authority from the Long Bill. A separate recommendation for new legislation would add the money back with appropriate legal authorization.

R14 Safety net programs: Staff recommends an increase of $749,728 cash funds to spend down accumulated balances for safety net programs.

R15 CHASE ADMINISTRATION: Staff recommends an increase of $761,794 total funds and 5.4 FTE to improve the Department's oversight of the Healthcare Affordability and Sustainability (HAS) Fee, development of performance payments for hospitals as required by S.B. 17-267, and analysis of the drivers of Medicaid expenditures on hospitals.

R16 EMERGENCY TRANSPORT CPE: Staff recommends an increase of $18.6 million total funds, but a decrease of $710,560 General Fund, to take funds spent by local governments on emergency medical transportation (EMT) and certify those funds as public expenditures in order to claim an estimated $9.5 million in matching federal funds through Medicaid. The Department will use a portion of the increased revenue to offset General Fund costs for administration, similar to the process used for other certified public expenditures, and the bulk to increase reimbursements for public EMT providers by an estimated $8.6 million.

R17 SINGLE ASSESSMENT TOOL: Staff recommends a decrease of $5.1 million total funds, including a decrease of $2.5 million General Fund, to shift funding for a single assessment tool for intellectual and developmental disabilities, authorized by S.B. 16-192, to future years.

R18 COST ALLOCATION: Staff recommends $366,400 total funds, including $120,050 General Fund, to increase contract services that assist in complying with federal cost allocation procedures necessary to claim federal matching funds for administrative functions, especially those performed by vendors that may have costs that are not eligible for Medicaid reimbursement.

R19 IDD WAIVER CONSOLIDATION: Staff recommends $478,500 total funds, including $239,250 General Fund, for two years of contract services for additional work identified as necessary to complete the consolidation of Home- and Community-Based Services waivers for adults with intellectual and developmental disabilities as directed by H.B. 15-1318.

BA11 COUNTY ADMINISTRATION: Staff recommends continuation of a supplemental decision to consolidate funds for county administration in one line item.

BA12 PUBLIC SCHOOL HEALTH SERVICES: Staff recommends $5.0 million total funds, including $2.6 million certified public expenditures, for projected changes in caseload and utilization for the Public School Health Services program.

BA14 BENEFITS UTILIZATION SYSTEM: Staff recommends $230,000 total funds, including $115,020 General Fund to continue information technology support for the system that manages needs assessments and eligibility for long-term services and supports programs.

NP FAMILY MEDICINE RESIDENCIES: Staff recommends $600,000 total funds, including $300,000 General Fund, for two new family medicine residency programs at Peak Vista in Colorado Springs and Skyridge in Lone Tree.

NP CBMS-PEAK: Staff recommends $467,661 total funds, including $500,178 General Fund, for increasing costs of the Colorado Benefits Management System (CBMS) that determines eligibility for Medicaid and other public assistance programs.

NP RISK MANAGEMENT CYBERSECURITY: The staff recommendation on risk management cybersecurity is pending JBC decisions on funding for the Office of Information technology.

NP OIT HCPF SECURITY: Staff recommends a decrease of $84,054 total funds, including $23,1884 General Fund, for transfer to the Governor's Office of Information Technology to address information technology security issues within the Department.

STAFF INITIATED – VETERANS OUTREACH: Staff recommends $25,000 total funds, including $12,500 General Fund, to explore opportunities for improved outreach to connect veterans with available federal and state services, which could improve veteran health outcomes and reduce Medicaid expenditures.

CENTRALLY APPROPRIATED LINE ITEMS: Staff recommends adjustments to centrally appropriated line items for the following: state contributions for health, life, and dental benefits; short-term disability; supplemental state contributions to the Public Employees' Retirement Association (PERA) pension fund; shift differential; salary survey; workers' compensation; legal services; administrative law judges; payment to risk management and property funds; Capitol complex leased space; payments to the Governor's Office of Information Technology (OIT); and CORE operations.

TRANSFERS TO OTHER AGENCIES: The staff recommendation on transfers to other state agencies is pending JBC figure setting decisions for the receiving agencies, primarily the Department of Public Health and Environment.

ANNUALIZE PRIOR YEAR BUDGET ACTIONS: Staff recommends adjustments for out-year impacts of prior year legislation and budget actions. The largest increase is for H.B. 17-1353, which included performance-based payments for primary care and behavioral health services. It also included changes in the operation of the Accountable Care Collaborative and projected offsetting savings. The largest decrease is for FY 17-18 R6, which included the end of the primary care rate bump and a decrease in behavioral health capitation rates. These two initiatives relate to each other and the savings from R6 offset the increases from H.B. 17-1353.

OTHER: Staff recommends miscellaneous other changes, mostly related to fund source adjustments for tobacco revenues. The final fund source adjustments are pending the March revenue forecast.

LEGISLATION

R7 COMMUNITY TRANSITION SERVICES: Staff recommends legislation (#9 on the JBC's list of potential legislation) to make one year of transition services available for Medicaid clients moving from an institutional setting to a community setting.

R13 ALL-PAYER CLAIMS DATABASE: Staff recommends legislation (item #11 on the JBC's list of potential legislation) to allow state financing for the All-Payer Claims Database (APCD), rather than grant funding, and to authorize a scholarship program for research using the APCD.

MAJOR DIFFERENCES FROM THE REQUEST

The largest differences between the request and the JBC staff recommendation are due to the JBC staff using the Department's February 2018 forecast of expenditures for Medical Services Premiums, the Children's Basic Health Plan, and the Medicare Modernization Act

DECISION ITEMS AFFECTING MULTIPLE DIVISIONS

➔ R6 HOME CARE VISIT VERIFICATION

REQUEST

The Department requests a decrease of $1.2 million total funds, including a decrease of $1.2 million General Fund, and an increase of 7.0 FTE to implement a federally required electronic system to track and verify the time that personal care and home health workers spend on home visits. The requested FTE, combined with the FTE approved in a related supplemental, annualize to 8.0 FTE. The Department proposes that 4.0 FTE would be time-limited through FY 2020-21, as they relate to temporary needs for project development, testing, and fraud investigation (for an expected initial spike in fraud cases).

The federal law requires an electronic visit verification system for personal care services by January 2019 and for home health services by January 2023. Failure to comply results in a reduction in the federal match rate for the effected services. The Department proposes implementing electronic visit verification for both services by January 2019: (1) to avoid the need for two separate rounds of bidding, stakeholder engagement, and training; (2) to accelerate the expected savings from fewer billed hours; and (3) to maintain consistency in the billing methods for personal care and home health, especially for providers who offer both services.

The JBC previously approved a supplemental for the Department to begin work in FY 2017-18. The FY 2018-19 request includes costs to continue development and then operate the system. These costs are more than offset by an expected decrease in billed hours for personal care and home health, based on the experience of other states that have implemented similar systems.

RECOMMENDATION

Staff recommends approval of the request with the following modifications:

- Apply the JBC's common policy to not fund certain benefits in the request year for new FTE
- Correct technical errors that the Department acknowledges in the Department's calculation of the cost for the new FTE
- Do not assume any savings unless and until actual utilization decreases

TWO-STAGE IMPLEMENTATION OPTION

Federal regulation requires states to implement an electronic visit verification system, and so the main decision with this request is whether to implement a system all at once, as proposed by the Department and recommended by the JBC staff, or in two stages with personal care services by January 2019 and home health services by January 2023. Some providers advocate for a two-stage implementation. First, the Department forecasts the system will result in lower overall payments to home care providers and the General Assembly has tried to increase rates for these same providers in recent years. In FY 2017-18, for example, the General Assembly added approximately $11.8 million total funds to increase rates for personal care and home health providers. Second, providers express anxiety about the Department's recent track record with new payment systems and question whether the Department can successfully implement an electronic visit verification system in the available time.

The JBC staff does not recommend a two-stage implementation. Regarding the electronic visit verification system lowering payments to providers, the system will only lower payments for providers that are billing for more units than they actually deliver. If rates for the providers are too low, turning a blind eye to fraud or careless timekeeping is not a good solution, as it benefits only providers bending the rules.

Regarding the Department's ability to successfully implement a new system, the Department indicates there are many proven off-the-shelf products that need only minor modifications to fit the Department's needs. The Department is working with the Office of Information Technology to implement the system and plans a phased roll-out that will delay tying claims authorization to successful electronic verification until provider data is tested and confirmed in the new system. The federal law provides that if a state makes a good faith effort to comply with the federal regulations and an unavoidable system delay occurs, then the reduction in the federal match rate will not apply in the first year. Thus, in the first year, and only the first year, the Department has an opportunity to temporarily pull the plug on the electronic visit verification system without incurring a federal funds penalty, should an unavoidable system delay occur. Also, after considering the inadequate provider outreach and training that occurred with the Department's new Medicaid Management Information System, the JBC staff is recommending the Department's FTE request in full for 8.0 FTE (8.0!) to implement a time clock.

A two stage implementation is less cost efficient. The Department argues it would need to keep temporary development FTE on for a longer period of time, at a cost of $295,225 per year. Also, there would be some additional stakeholder outreach costs with two separate deployment rounds. These factors combined would increase administrative costs by $1.5 million total funds over the life of the project. In addition, any savings that might be achieved as a result of fewer billed units would be delayed. The Department estimates the delayed savings would cost an additional $16.8 million total funds ($8.4 million General Fund), or an average of $3.4 million ($1.7 million General Fund) per year, until the second stage is implemented in FY 2022-23. To the extent an electronic visit verification program reduces expenditures, the Department's concern about delayed savings is relevant, but in the next subheading the JBC staff raises concerns that the Department's request might overstate the savings.

Estimated Savings

The JBC staff is not confident in the Department's assumption that an electronic visit verification system will result in fewer home care billed units. The Department consulted with a vendor that identified savings from implementing similar systems of five to seven percent in Texas, eight percent in Oklahoma, and forty-six percent in Florida. However, the experiences of other states may not be indicative of what will occur in Colorado. Also, the savings in other states might be related to factors other than implementing an electronic visit verification system. For example, billed hours were decreasing in Florida for several years prior to the electronic visit verification system (although forty-six percent was the largest year-over-year decrease). Finally, the data about savings in other states is primarily from a vendor with a financial interest in bidding to implement a system in Colorado.

The Department assumed a one percent decrease from the otherwise projected increase for services requiring an electronic visit verification, which is significantly lower than the 5-10 percent savings predicted by the vendor. The Department's projected FY 2018-19 savings of $3.6 million total funds, including $1.8 million General Fund, is for only a partial year with an electronic visit verification

system. In FY 2019-20 the Department projects savings of $9.4 million total funds, including $4.7 million General Fund.

The JBC staff recommends not reducing the budget until the system is implemented and actual data exists to show whether home care billed units have decreased. Compared to the Department's request, this component of the JBC staff recommendation would result in higher appropriations for FY 2018-19 of $3.6 million total funds, including $1.8 million General Fund.

After being informed of the JBC staff's concerns, the Department presented some additional information about Oklahoma's experience with an EVV system that might support the projected savings. In Oklahoma, the average scores on assessments of need increased by a statistically significant margin during the phase-in of the EVV system, but the average units billed per member decreased. At the same time, client complaints about inadequate service delivery decreased and a downward trend in the utilization of nursing homes (the presumed alternative to home care services) continued. However, the report also indicated that Oklahoma successfully implemented during this time frame annual reevaluations of the medical level of care of clients receiving services and implemented additional efforts (unspecified in the report) to tighten evaluations that verify new applicants meet the medical level of care, resulting in fewer clients qualifying for services. It is possible that Oklahoma's efforts to make it more difficult to qualify for services carried over to influence the utilization of services by people who did qualify, and perceptions by those clients about whether the services provided were sufficient. While the information from Oklahoma is more compelling than the information in the original budget request, the JBC staff still believes the best approach is to assume no savings and see if an actual trend emerges to justify a decrease in future forecasts.

SUMMARY TABLE

The staff recommendation is summarized in the table below.

R6 Home Care Visit Verification				
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	FTE
FY 17-18 Approved Supplemental				
Startup costs				
Development staff	$45,444	$4,544	$40,900	0.5
Contractor startup	196,267	19,627	176,640	
IT system interfaces	100,000	10,000	90,000	
Ongoing costs				
Operations staff	35,039	3,504	31,535	0.3
TOTAL FY 17-18	**$376,750**	**$37,675**	**$339,075**	**0.8**
FY 18-19 Recommendation				
Startup costs				
Development staff	232,494	48,441	184,053	3.9
Contractor startup	392,533	39,254	353,279	
IT system interfaces	200,000	20,000	180,000	
Stakeholder engagement	8,736	4,368	4,368	
Ongoing costs				
Operations staff	282,317	68,109	214,208	3.9
Contract services	1,625,280	406,320	1,218,960	
Subtotal - Costs	*2,741,360*	*586,492*	*2,154,868*	*7.8*
Home care billed hours	0	0	0	
TOTAL FY 18-19	**$2,741,360**	**$586,492**	**$2,154,868**	**7.8**

R6 Home Care Visit Verification				
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	FTE
Change from FY 17-18	$2,364,610	$548,817	$1,815,793	7.0

➔ R7 COMMUNITY TRANSITION SERVICES

REQUEST

The Department **requests legislation** (#9 on the JBC's list of potential legislation) to allow Medicaid clients moving from an institutional setting to a community setting to access the following transition services for a period of up to one year: intensive case management, household set-up, home delivered meals, peer mentorship, and independent living skills training. The Department indicates these are the most effective and utilized services from the expiring Community Choice Transitions (CCT) demonstration. The federal authorization for the CCT demonstration does not allow new clients after December 31, 2018. To continue this subset of the CCT services, the Department would need a bill providing state authorization for the services, and federal approval. The projected increased costs for the transition services are more than offset by an expected decrease in payments for nursing homes, resulting in a net savings.

In a second part of the request, the Department proposes increasing funding for existing services that provide counseling on the options available for people wanting to transition to a community setting. Expanding options counseling could be done without legislation. Federally required surveys identify more people expressing an interest in transitioning to a community setting than can be reached with the current funding for options counseling. With the additional funding for options counseling, the Department projects an increase in the number of people using transition services from those reached by the expiring CCT program.

Finally, the Department proposes that the General Assembly allow 5.0 FTE currently financed through December 2020 with federal grant funds for the CCT to continue into the future with a mix of state and federal funds, in order to administer the requested ongoing transition services. If the General Assembly approves the transition services, the administrative FTE would appear as an annualization in the FY 2020-21 budget, when the authorization for the federally funded FTE expires. Beginning in FY 2020-21 the FTE would have a 50.0 percent General Fund match.

The legislature approved the CCT through appropriations for the required state match, and so the Department is not proposing to backfill an expiring grant program created with purely federal funds. However, the current CCT demonstration includes federal grant funds for administration and earns bonus federal funds that will not be available with the requested ongoing benefits.

In addition to projecting a savings from the request, the Department views the transition services as important in demonstrating compliance with the U.S. Supreme Court's Olmstead decision that requires states to provide community-based care when appropriate, rather than placing people with disabilities in institutional settings.

The request includes increases for administrative costs, the new transition services benefits, the expected increase in utilization of existing community-based service benefits, and the expanded options counseling. These costs are more than offset by a projected savings from a reduction in

utilization of nursing homes and other institutions. After a year, the Department assumes people form connections allowing them to live in the community without transition services, but they will continue to use community-based long-term services and supports that are already part of the Medicaid benefit package for maintenance. Without the request, nursing home utilization is projected to increase due to the end of the current CCT program (this cost is included in the forecast adjustments *R1 Medical Service Premiums* and *R5 Office of Community Living*).

The Department would use rule making authority to ensure that the transition services are targeted to a similar population as the current CCT program. The services would not be available to clients leaving an institution after a short duration rehabilitation stay. Referral for transitions services and screening for eligibility based on the targeting criteria will occur during the options counseling.

RECOMMENDATION

Staff recommends:

- Sponsoring the **requested legislation** (#9 on the JBC's list of potential legislation) to make one year of transition services available for Medicaid clients moving from an institutional setting to a community setting
- Adding funds for housing vouchers that were not requested by the Department
- Including the requested increase for options counseling in the Long Bill (rather than the special bill), but assuming no increase in savings as a result of the additional options counseling
- Assuming costs and savings based on a JBC staff calculation that is updated to match the Department's February forecast and corrects some inconsistent assumptions and technical errors in the Department's request

SPONSORING LEGISLATION

The existing CCT demonstration has a successful track record of helping people move from an institutional setting to a community setting, primarily using the five transition services included in the Department's request. For example, the CCT helped 103 people transition in 2017 and 83 people transition in 2016. Over the life of the program, 93 percent of the clients are still in a community setting two years after transitioning. The Department indicates it is rare for the targeted long-term institutional residents (i.e., those not in an institution for a temporary rehabilitation) to transition to a community setting without the transition services offered through the CCT.

There is reason to believe there are more people in Colorado who could move from an institutional setting to a community setting. In federally required annual surveys (the Minimum Data Set) roughly 2,000 residents express an interest in moving from their institutional setting to a community setting each year (2,083 in FY 2016-17 and 1,958 in FY 2015-16). The Colorado Long-term Services and Supports Scorecard reports 13.4 percent of Colorado nursing home residents aged 65+ have low care needs that could potentially be met in the community, which ranks 34th among states nationally.

People generally will not receive the transition services unless they are actually moving from an institutional setting to a community setting and generating savings. The exception is intensive case management that begins while a person is in an institutional setting and could be provided to some people who do not actually succeed in transitioning. The Department's estimate of the number of transitions that will actually occur might be too high or too low, but the risk that the cost of the additional transition services will be more than the offsetting savings from decreased utilization of

nursing homes is low. In other words, the forecast risk is not so much whether the state will save money, but how much savings will be generated.

HOUSING VOUCHERS

Without additional housing vouchers, many people who want to transition from an institutional setting to a community setting would not have the resources for the move. The current CCT includes General Fund for housing vouchers administered by the Department of Local Affairs, but the Department did not include additional housing vouchers in the request.

The Department believes there are enough people who want to transition who have sufficient housing options to justify the estimated annual transitions without funding for additional housing vouchers. However, the Department acknowledged that the success of the current CCT is greatly facilitated by the availability of housing vouchers and that a request for more housing vouchers could be forthcoming in the future, if the General Assembly approves the proposed transition services.

The JBC staff views the housing vouchers that are currently part of the CCT as a critical component for the success of transition services. According to the Department, approximately 56 percent of current CCT participants use housing vouchers to transition. The JBC staff assumes 56 percent of the people served with the proposed transition services will also need housing vouchers to complete their transitions.

OPTIONS COUNSELING

In FY 2016-17, only 404 out of 2,083 institutional residents expressing an interest in transitioning to the community were referred for options counseling, which is an improvement from the 172 out of 1,958 in FY 2015-16. The Department believes the low referral rate for options counseling is due to a lack of resources and infrastructure for the Aging and Disability Resource Centers (ADRCs) that perform the options counseling.

Whether the JBC decides to sponsor legislation providing state authority for the requested transition services or not, it is reasonable to expect that Medicaid-funded residents of institutions should be able to learn about community alternatives. The cost of providing additional options counseling is relatively small and the options counseling could help in demonstrating the state's compliance with the Supreme Court's Olmstead decision.

The Department assumed that an increase in options counseling would result in an increase in successful transitions to the community, but this assumes the current pace of transitions to the community is sustainable with the current level of funding for options counseling. The JBC staff is less certain. The CCT has been transitioning clients from institutions to the community since 2013. If Colorado is doing a good job of preventing people from entering institutions unless they need that level of service, then it should get harder over time to identify people who can successfully make the transition from an institution to the community. To be conservative, the JBC staff assumes that additional options counseling will help the Department maintain the current rate of transitions to the community, rather than increasing that rate. If additional options counseling results in more transitions, then that will generate more savings that will be accounted for in a supplemental, but there would be budget risk in counting on additional savings before those savings materialize.

JBC STAFF CALCULATION

Following the November budget submission, the JBC staff and the Department jointly agreed that the request included some internally inconsistent assumptions and minor technical errors. Also, in February the Department submitted a new enrollment and expenditure forecast. The JBC staff recommendation is updated to account for these factors. Not all of the JBC staff's adjustments to the Department's request have been reviewed by the Department and the Department of Local Affairs. Also, if the JBC decides to introduce a bill, then Legislative Council Staff will perform an independent analysis of the costs for the fiscal note. This might result in slightly different figures in a fiscal note for the legislation than the staff recommendation.

The table below summarizes the JBC staff recommendation. The bottom of the table includes a comparison between the JBC staff recommendation for General Fund and the Department's request for General Fund with rows highlighting what drives the dollar difference.

R7 Transition Services - JBC Staff Recommendation				
	FY 18-19	FY 19-20	FY 20-21	FY 21-22
Health Care Policy and Financing				
Administration	$337,500	$0	$240,310	$458,159
Transition services	679,892	1,345,089	1,391,009	1,438,749
Community-based LTSS utilization	1,060,132	3,174,213	5,332,531	7,511,556
Nursing home utilization	(2,761,640)	(8,362,654)	(13,688,868)	(18,823,082)
Subtotal - Health Care Policy and Financing	*(684,116)*	*(3,843,352)*	*(6,725,018)*	*(9,414,618)*
Local Affairs				
Housing Vouchers	200,256	588,252	963,732	1,324,908
TOTAL - Legislation	**($483,860)**	**($3,255,100)**	**($5,761,286)**	**($8,089,710)**
Options Counseling - Long Bill	241,942	241,942	241,942	241,942
TOTAL - R7 Transition Services	**($241,918)**	**($3,013,158)**	**($5,519,344)**	**($7,847,768)**
FTE	0.0	0.0	2.1	5.0
General Fund	(124,887)	(1,212,453)	(2,277,806)	(3,261,430)
Federal Funds	(51,566)	(1,800,705)	(3,241,538)	(4,586,338)
Department General Fund Request	**($703,203)**	**($3,161,590)**	**($5,982,106)**	**($8,598,852)**
Staff Rec. Higher/(Lower)	$578,316	$1,949,137	$3,704,300	$5,337,422
Add Housing Vouchers	200,256	588,252	963,732	1,324,908
No additional savings from options counseling	127,702	457,358	820,892	1,146,050
Feb forecast update/Fix inconsistent assumptions	250,358	903,527	1,919,676	2,866,464

➔ R8 MEDICAID SAVINGS INITIATIVES

REQUEST

The Department requests a net decrease of $1.4 million total funds, including a reduction of $2.2 million General Fund, and an increase of 5.8 FTE for five measures designed to decrease Medicaid expenditures.

RECOMMENDATION

The table below summarizes the JBC staff recommendation. The initiatives, the associated JBC staff recommendations, and any differences from the Department's request, are discussed in the subheadings below the table.

R8 Medicaid Savings Initiatives					
	Total Funds	General Fund	Other State	Federal Funds	FTE
FY 18-19					
Prior Authorization Reviews	*($256,822)*	*($149,807)*	*($8,084)*	*($98,931)*	*2.5*
Benefits collaborative	202,074	101,037	0	101,037	2.5
Contractor	1,042,615	260,654	0	781,961	
Decreased utilization	(1,501,511)	(511,498)	(8,084)	(981,929)	
Limit multistate Medicaid enrollment	*(1,039,523)*	*(320,526)*	*16,855*	*(735,852)*	*1.7*
Automatic notifications	602,959	109,122	56,693	437,144	
Staff follow-up	103,515	33,955	17,803	51,757	1.7
Per member payments	(1,745,997)	(463,603)	(57,641)	(1,224,753)	
Trust Recoveries	*125,187*	*(1,336,583)*	*2,798,353*	*(1,336,583)*	*1.7*
Investigators	125,187	62,594	0	62,593	1.7
Recoveries & offset	0	(1,399,177)	2,798,353	(1,399,176)	
Public transport	*(412,247)*	*(206,124)*	*0*	*(206,123)*	*0.0*
Vendor	150,000	75,000	0	75,000	
Non-emergency medical	(216,378)	(108,189)	0	(108,189)	
Non-medical	(345,869)	(172,935)	0	(172,934)	
Parental Fee	*763,703*	*121,712*	*62,997*	*578,994*	*0.0*
System changes	763,703	121,712	62,997	578,994	
Fee revenue & offset	0	0	0	0	
TOTAL 18-19	**($819,702)**	**($1,891,328)**	**$2,870,121**	**($1,798,495)**	**5.9**
FY 19-20					
Prior Authorization Reviews	*($870,013)*	*($439,845)*	*($16,762)*	*($413,406)*	*3.0*
Benefits collaborative	239,668	119,834	0	119,834	3.0
Contractor	2,003,849	500,963	0	1,502,886	
Decreased utilization	(3,113,530)	(1,060,642)	(16,762)	(2,036,126)	
Limit multistate Medicaid enrollment	*(2,916,022)*	*(760,368)*	*(99,841)*	*(2,055,813)*	*2.0*
Automatic notifications	73,440	26,350	10,429	36,661	
Staff follow-up	112,893	37,030	19,417	56,446	2.0
Per member payments	(3,102,355)	(823,748)	(129,687)	(2,148,920)	
Trust Recoveries	*138,900*	*(1,609,561)*	*3,358,023*	*(1,609,562)*	*2.0*
Investigators	138,900	69,450	0	69,450	2.0
Recoveries & offset	0	(1,679,011)	3,358,023	(1,679,012)	
Public transport	*(580,181)*	*(290,091)*	*0*	*(290,090)*	*0.0*
Vendor	155,000	77,500	0	77,500	
Non-emergency medical	(216,378)	(108,189)	0	(108,189)	
Non-medical	(518,803)	(259,402)	0	(259,401)	
Parental Fee	*207,529*	*(992,782)*	*2,072,652*	*(872,341)*	*0.0*
System changes	206,570	33,919	18,426	154,225	
Notifications	959	344	136	479	
Fee revenue & offset	0	(1,027,045)	2,054,090	(1,027,045)	
TOTAL 19-20	**($4,019,787)**	**($4,092,647)**	**$5,314,072**	**($5,241,212)**	**7.0**

PRIOR AUTHORIZATION REVIEWS (PARS)

The Department proposes increasing requirements for prior authorization review before Medicaid will cover certain services, in order to ensure medical necessity and that other less costly alternatives have been exhausted. The Department estimates implementing additional PARs requires 3.0 FTE (2.5 FTE in the first year) and an additional roughly $2.0 million annually in contract services to review PAR requests from providers. These costs are offset by projected savings due to decreased utilization. The Benefits Collaborative analyzes medical research, consults stakeholders, and develops the criteria for when Medicaid will cover the care. Providers submit requests to a vendor that performs the prior

authorization review based on the criteria developed by the Benefits Collaborative and approved by the Medical Services Board. The Department did not identify specific new PARs in the request, because the Benefits Collaborative needs to do the analysis before determining what new PARs are appropriate. For cost estimating purposes, the request assumes that new PARs will reduce utilization by 3.14 percent for cosmetic surgeries, back surgeries, outpatient speech therapy, oxygen, prosthetics and orthotics, adult long-term home health, and vision.

The requested contract services to review the PARs includes a 25 percent cushion to provide flexibility in the event that the Benefits Collaborative recommends different PARs requiring more reviews than assumed. The amount paid to the contractor will depend on the actual PARs implemented and the associated utilization and will not be fixed based on the appropriation.

Recommendation

Staff recommends approval of the request, with modification to apply the JBC's common policy regarding benefits for new FTE and correct a technical error in the Department's request that did not account for the expected January 2019 implementation of new PARs. Good prior authorization practices require a balancing act. On the one hand, prior authorization requirements can speed the adoption of practices that are more cost effective, or even result in better health outcomes. On the other hand, prior authorization requirements can be time consuming and burdensome for providers and patients to navigate, and in the worst cases result in the delay or denial of needed care. To strike the right balance, it is essential that the Department have adequate staff and contract resources to process all the available clinical evidence and stakeholder input, develop quality PAR requirements, educate providers about the PARs, thoroughly review each request, investigate appeals, track the effects of the PARs on expenditures and patient outcomes, and update PAR requirements appropriately with changes in clinical findings, provider practices, patient outcomes, and treatment costs.

It is difficult for the JBC staff to evaluate the department's forecast, for both the contractor costs to review the PAR requests and the expected savings from decreased utilization, without knowing the PAR requirements that will be recommended by the Benefits Collaborative. Some of the Department's assumptions appear questionable. For example, the Department assumes the savings from a denial is equal to the cost of the unit of service avoided, but in many cases people will use an alternative service and the savings would be the incremental difference between the denied service and the alternative. However, even the incremental difference from the alternative service could be a simplistic savings assumption, if the alternative service results in a different health outcome that affects costs for other services. As another example, the Department assumed a PAR requirement would be placed on vision services with a 3.14 percent denial rate. At this denial rate, the Department would need to review 32 PAR requests on average to get 1 denial. At the contractor's average rate per PAR review of $22.75 the Department would spend $728 to get one vision service denial, which is more than the $144.03 cost per unit of vision services. The JBC staff assumes that the Benefits Collaborative would weed out cost ineffective PARs and that if a vision PAR is implemented it would be done in a way that generates a significantly higher denial rate and/or a significantly lower review cost. When the overall averages the Department used for forecasting purposes are applied to the specific example of vision services, they result in a ridiculous outcome that is, hopefully, not representative of what the Department would actually implement.

Despite these concerns, the JBC staff decided to recommend the request. A well designed PAR should save the insurer money and the Department's request uses a relatively modest savings assumption of

$3.1 million per year relative to the cost of $2.2 million per year for PAR development and reviews. If the Department cannot get $3.1 million in savings from $2.2 million worth of PAR reviews, then the problem is probably with the particular PAR requirements selected. Another significant factor that swayed the JBC staff is the Department's relatively low reliance on PAR requirements currently compared to other insurers. The benefit of PARs as a cost containment strategy must be weighed against the administrative burden on providers and clients and the potential for inappropriate denials. The staff recommendation will result in a higher PAR burden on providers and clients, but the Medicaid PAR standards will still be well below the typical requirements of other insurers.

LIMIT MULTISTATE MEDICAID ENROLLMENT

The Department proposes sending automatic notifications that require clients with Medicaid coverage in another state to attest their residency in Colorado or have their Colorado eligibility terminated. The Department receives a regular report from the federal government of people enrolled in Colorado's Medicaid program who are also enrolled in another state Medicaid program. By more quickly ending eligibility for people who reside in another state, the Department could reduce the risk for fraud, and prevent unnecessary payments to providers reimbursed on a per member per month basis. Specifically, the Department expects to reduce per member per month payments to the Regional Accountable Entities in the Accountable Care Collaborative and to the adult dental administrative service organization.

There are other managed care providers paid on a per member per month basis, such as behavioral health providers, but these other managed care rates are cost-based. For cost-based rates the Department assumes that decreases in enrollment will be offset by increases in rates per member for no net change in total expenditures.

Sending automatic notifications requires one-time programming costs, estimated at $547,878 total funds, and on-going mailing costs, estimated at $55,080 total funds, in FY 2018-19. In addition, the Department requests two new positions (1.7 FTE in the first year) to follow up on cases not resolved by the system automation, and to coordinate with other states. If a person on the multistate enrollment report resides in Colorado, then the Department wants to make sure the individual is removed from enrollment in other states, so the person does not appear on future reports. These costs are offset by a projected decrease in per member per month payments of $1.7 million total funds ($463,603 General Fund) in FY 2018-19, increasing to $3.1 million total funds ($823,748 General Fund) when fully annualized in the second year. Based on the number of Medicaid clients enrolled in Colorado and another state with no Colorado fee-for-service claims in the prior year, the Department estimates the policy change could reduce Medicaid enrollment by 20,717.

Senate Bill 10-167 (Boyd/Riesberg) included, among other provisions, $200,000 total funds ($100,000 General Fund) for the counties with the highest matches on the federal report, and 1.0 FTE for the Department, specifically to investigate cases of multistate enrollment. Despite this funding, the number of matches increased on the federal report of people enrolled in Medicaid in Colorado and another state. Other policy changes, including automatic reenrollment[1] of people who meet the income eligibility criteria and the federal Affordable Care Act (ACA) Medicaid eligibility expansion, compounded the problem. The Department proposes that the funding from S.B. 10-167 would

[1] Automatic reenrollment occurs when the Department can verify eligibility information, including income, using existing data or interfaces and the individual has no changes to report. Automatic reenrollment is now required for some populations by the federal Affordable Care Act.

continue, but be distributed to the counties based on workload. Automated notifications may reduce the number of investigations of multistate enrollment that counties need to initiate, but the Department expects the automatic notifications to generate questions and responses that require processing by counties, and so the county workload will change, rather than diminish.

YEAR	NUMBER OF MATCHES IN THE HIGHEST QUARTER	COMMENTS
2010	12,880	Pre-auto reenroll
2011	14,903	
2012	24,017	Post-auto reenroll
2013	24,615	
2014	44,346	Post ACA
2015	38,968	
2016	40,817	
2017	40,032	

Recommendation

Staff recommends approval of the request, with modification to apply the JBC's common policies regarding first year benefits for new FTE. The request will reduce per member per month payments for people who do not reside in Colorado and reduce the risk of fraud. Previous efforts to provide incentives for counties to investigate cases of multistate enrollment have not reduced the numbers. The automated notices will increase the workload for some clients to demonstrate eligibility, but the additional requirement is a relatively minimal self-attestation that they reside in Colorado.

TRUST RECOVERIES

The Department proposes adding 2.0 FTE (1.7 FTE in the first year) to pursue resources in trusts that Medicaid is required to recover. Pursuant to state and federal law, any Medicaid recipient who receives supplemental income, including income from trusts, must apply this income to the cost of benefits. When a Medicaid client dies, the Department is required to recover assets from trusts for a portion of the cost of care provided. The Department currently devotes approximately 2.0 FTE to trust recoveries. When the Department learns about trust assets through an enrollment application, the FTE review the effects on eligibility and handle any associated recoveries and legal proceedings. The FTE also investigate when the Department learns about assets in trusts from court records, fraud detection efforts by counties and the Attorney General, or other sources. The Department indicates it is currently understaffed to follow all credible leads, resulting in under-recoveries from trusts. For example, the Department is aware of 1,700 active disability trusts and a review revealed trusts that should have been terminated, as well as trusts being mismanaged relative to Medicaid requirements, but the Department does not have staff to investigate all the cases.

If the additional FTE are approved, the Department projects recoveries from trusts will increase. To be conservative, and to account for diminishing returns of adding FTE, the Department assumes additional trust recoveries equal to 50 percent of the current average recoveries per FTE.

Recommendation

Staff recommends approval of the request with modification to apply the JBC's common policies regarding first year benefits for new FTE. The Department is required by state and federal statute to recover funds from Medicaid beneficiaries' supplemental income from trusts. The request would not change existing state and federal laws regarding trusts and the amounts recoverable by Medicaid. It would improve enforcement of the existing laws, saving General Fund and potentially preventing audit findings and federal disallowances. The Department has more leads on recoverable funds from

trusts than it can investigate with current resources. The cost of additional trust investigators is more than offset by the projected additional trust recoveries.

The JBC staff recommendation results in a net increase of $125,187 total funds and 1.7 FTE, but a decrease of $1.4 million General Fund after accounting for the expected increase in trust recoveries.

PUBLIC TRANSPORT

In the first part of the public transport request the Department proposes using discounted bus fares from the Regional Transportation District (RTD) to reduce transportation costs. Medicaid currently pays for busses and other non-emergency medical transportation to and from medical appointments when a member has no other means of transportation. Some Medicaid members, including seniors, students, and people with disabilities, could qualify for reduced fares from RTD. By slightly increasing administrative payments to the contract vendor to identify the clients who qualify for reduced fares and purchase discounted passes, instead of full-price passes, for these clients, the Department could reduce transportation expenditures. The Department would only achieve the savings for qualifying clients in the RTD zone. Medicaid clients would experience no change in their transportation benefit as a result of this component of the request.

In the second part of the public transport request, the Department proposes adding an option for Medicaid clients to use public transportation for covered non-medical transportation. Medicaid pays for non-medical transportation, for example to and from an adult day facility or the grocery, for certain people with disabilities receiving waiver services. Trips are capped at two per week, except for trips to covered adult day facility services. Currently, trips must be made by taxi or mobility van. Offering a public transportation option expands the available choices of providers for clients. In some cases, public transportation might be more convenient and timely for clients, increasing client independence. The Department projects that a portion of higher cost taxi and mobility van trips will be replaced by lower cost public transportation trips, resulting in a net savings. In no case would clients be required to use public transportation instead of a taxi or mobility van.

Recommendation

Staff recommends the request, but with a lower savings projection for the non-medical transportation component. For the non-medical transportation the Department assumed 13 percent of current taxi and mobility van trips would be replaced by public transportation trips, based on the average percentage of non-emergency medical transportation trips by public transportation. The JBC staff wonders how many people accustomed to taking taxis and mobility vans will switch to public transit, and how quickly they will switch. In addition, the JBC staff questions the Department's assumption that there will be no increase in utilization with a new public transportation option. To arrive at a more conservative estimate of the savings, the JBC staff took the Department's total projected public transportation trips and assumed 75 percent would replace taxi and mobility van trips and 25 percent would be new utilization. This resulted in an estimated savings for this component of the request of $345,869 total funds ($172,935 General Fund) in the first year and $518,803 total funds ($259,401 General Fund) in the second year, which is less than the Department's projected savings by $153,704 total funds ($76,852 General Fund) in the first year and $230,519 total funds ($115,260 General Fund) in the second year.

PARENTAL FEE

The Department proposes seeking a federal waiver to collect a monthly premium, on a sliding scale based on family income, for the Children's Home and Community Based Services (CHCBS) waiver.

If the severity of a disability puts a child at risk of needing nursing home care, federal Medicaid eligibility rules treat the child as a family of one and disregard parental income for the waiver, and so there might be families with children enrolled that have an ability to pay a parental fee. The proposed fees would be similar to the charges for the Medicaid buy in for people with disabilities.

The Department is concerned that the current structure of the CHCBS waiver creates an inequity. If a child is deemed at risk of placement in a nursing home, then the family can access Medicaid services for the child at no cost. If a child has a disability that is slightly less severe, then the family would need to pay to buy in to Medicaid. A buy in family could potentially have less income than a CHCBS family receiving services for free.

The CHCBS waiver covers case management and health maintenance activities. People eligible for the waiver also become eligible for the benefits provided to all Medicaid recipients. The Department's February forecast estimates the waiver will serve 1,586 kids in FY 2018-19 at an average cost of $15,404 annually for the waiver services and $33,000 annually for the State Plan services available to all Medicaid recipients.

The Department has not finalized a parental fee schedule, but for purposes of estimating the fiscal impact, the Department provided the following table.

Example Fee Tiers and Monthly Premium		
Tier	**FPL**	**Premium**
1	0-275%	None
2	276-400%	2.5% of income
3	401-525%	3.0% of income
4	526-650%	4.0% of income
5	651-899%	5.0% of income
6	900% and above	6.0% of income

For reference, the federal poverty guideline (FPL) for a family of three is $20,420. A family of three making 276% of the FPL would earn $56,359. If this family had to pay 2.5% of their income for a parental fee it would cost $1,409 annually.

The Department does not currently collect data on parental income for the children enrolled in the CHCBS waiver, and so to estimate the fiscal impact of charging a parental fee the Department investigated typical family income in the zip codes of current enrollees. The Department estimated 1,183 families, or 75 percent of the projected FY 2018-19 enrollees, would be required to pay the new parental fee, mostly in tiers 2-4. The estimated General Fund savings from a parental fee is $1.4 million annually when fully implemented. The Department projects starting the parental fee in October 2019. The savings is offset slightly by increased administrative costs for one-time system changes and on-going costs for notifications.

The General Assembly can authorize the Department to implement a premium through a budget action, because Section 25.5-5-203 (2), C.R.S., allows the Medical Services Board to establish limits on certain optional services, including the CHCBS waiver, to keep expenditures within appropriations. The possibility of an income-based limit on eligibility for the CHCBS waiver was contemplated in

Section 25.5-6-902 (10), C.R.S., that directed the Department to study the advisability of setting an upper limit on parental income for participation in the program, and other children's waivers.

Recommendation

Staff recommends approval of the request with the addition of a footnote. Requiring families with higher incomes to contribute to health insurance costs, and making the contributions somewhat consistent across services for families in similar circumstances, fits with the overall policy design and objectives of the Medicaid program. The appropriate tiers and income percentages are debatable and the JBC is being asked to act before the tiers and income percentages are finalized. The recommended footnote would: (1) make the policy change more transparent to the rest of the General Assembly; and (2) request that the Department update the health committees and the JBC on the planned tiers and income percentages before implementing the parental fee. If the General Assembly does not agree with the planned tiers and income percentages, there would be time in the 2019 legislative session to adjust the FY 2019-20 budget for different tiers and income percentages. Staff recommends the following footnote language:

> N *Department of Health Care Policy and Financing, Executive Director's Office, Information technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects; Colorado Benefits Management Systems, Operating and Contract Expenses – These line items include a total of $206,570 ($33,919 General Fund) for administrative costs related to collecting a monthly premium, on a sliding scale based on family income, for the Children's Home and Community Based Services waiver. It is the intent of the General Assembly that the Department of Health Care Policy and Financing submit the planned fees by income tier to the health committees and the Joint Budget Committee in the 2019 legislative session prior to implementing the fees in FY 2019-20.*

Asking a department to submit a response to a legislative inquiry is typically done in the annual request for information letter, but in this case the JBC staff views the request as more of a condition on the appropriation (or at least future appropriations), and so the JBC staff believes a footnote is the correct vehicle.

➔ R9/BA15 PROVIDER RATES

REQUEST

The Department requests a net increase of $27.8 million total funds, including $10.3 million General Fund, for changes to provider rates:

- Anesthesia – The Department proposes a decrease of $9.7 million total funds, including a decrease of $3.0 million General Fund, to reduce anesthesia rates to 100 percent of Medicare rates.
- Alternative Care Facilities – The Department proposes an increase of $15.7 million total funds, including $7.8 million General Fund, to increase rates for assisted living residences for the elderly and people with disabilities by 25% from $51.92 per day to $64.88 per day. The rate does not include room and board.
- Physician Services and Surgery – The Department proposes net budget neutral adjustments to rates based on place of service and for services that are below 80 percent or above 100 percent of the benchmark. To preserve budget neutrality, prevent disproportionate impacts on providers, and ensure investments in high value services, the Department may not rebalance all rates that otherwise meet the criteria.

- Nursing facility per diem – The Department proposes that the JBC **introduce legislation** (#10 on the JBC's list of potential legislation) to reduce the projected increase in expenditures under current law by $12.5 million total funds, including $6.3 million General Fund, through limiting the allowable growth of nursing home rates for one year to 1.0 percent, instead of 3.0 percent. The Department proposes establishing the resulting rates as the new base that can grow by up to 3 percent in future years. The Department explains that the request is to better align the increase for nursing facilities with the requested across-the-board increase for other providers and control the growth of Medicaid expenditures.
- Across-the-board rate increase – The Department proposes an increase of $34.4 million total funds, including $11.7 million General Fund, for a 0.77 percent rate increase for services not addressed in the other bullets that have traditionally been eligible for the common policy provider rate adjustment.

Most of the request and justification is contained in R9 and BA15 just corrects a technical omission from the original November request.

RECOMMENDATION

- Staff recommends the requested changes to rates for anesthesia, alternative care facilities, and physician services and surgery.
- The JBC staff does not recommend the requested legislation for a temporary change to the nursing facility per diem rate.
- For the across-the-board increase, staff recommends application of the JBC's common policy for community provider rates, which was pending at the time of this publication.

The Department's request and the staff recommendation for anesthesia, alternative care facilities, and physician services and surgery are consistent with the recommendations of the Medicaid Provider Rate Review Advisory Committee (MPRRAC).

R9 Provider Rates - Targeted Increases				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Anesthesia Services	($9,728,911)	($2,950,535)	($274,539)	($6,503,837)
Alternative Care Facilities	15,684,482	7,842,241	0	7,842,241
Physician Services & Surgery Rebalancing	0	0	0	0
TOTAL - Targeted Increases	**$5,955,571**	**$4,891,706**	**($274,539)**	**$1,338,404**

ANESTHESIA

The Department estimates aggregate payments for anesthesia services were 131.64 percent of the benchmark Medicare payments and no individual service payment was below 100 percent of the benchmark. The MPRRAC recommendation on anesthesia was not unanimous and the Department's recommendation report includes an appendix discussing some of the objections and the Department's analysis of those objections.

Advocates for higher anesthesia rates within the MPRRAC argued that a claims-based analysis of access to care does not indicate the adequacy of anesthesia rates. Anesthesia services typically support the work of another physician who makes the decision on whether to accept Medicaid patients. Anesthesiology providers typically enter contracts with hospitals that do not allow them to refuse services based on the payer. For this reason, Medicaid clients will receive anesthesia services regardless

of whether Medicaid pays at an appropriate level. Hospitals or anesthesiologists (depending on the contractual relationship) have to make up any shortfalls from other sources, including private pay. The Department did not dispute this argument in the recommendation report.

Some advocates for anesthesia rates argued that Medicare rates are not an appropriate benchmark, citing a report from the U.S. Government Accountability Office (GAO) identifying significant differences between private pay and Medicare rates. The Department examined the report and concluded that Medicare rates are an appropriate benchmark. The Department noted the age of the GAO report, published in 2007 and based on data from 2002 and 2004. In addition, the federal Centers for Medicare and Medicaid Services (CMS) wrote a response to the GAO report that identified a limitation to the analysis that it did not align with the most commonly utilized codes for Medicare clients and the Department states the same is true for Medicaid clients. Finally, while the report found a difference between typical private pay and Medicare rates, the Department noted that a difference does not necessarily indicate a deficiency. Medicare rates are generally set based on cost to ensure access to services, rather than comparable payment for services. The statutory goal of Medicaid payments is also to assure access, and to support appropriate reimbursement of high-value services, with no mention of providing reimbursement comparable to private pay.

Advocates for anesthesia note that other public rates, including Workers' Compensation, the Children's Basic Health Plan, and Medicaid's dental anesthesia rates, are higher than Medicaid's reimbursement for medical procedure anesthesia. Workers' Compensation is beyond the purview of the Department and the Children's Basic Health Plan is not comparable as a capitated managed care program with bundled payments, but the Department made note of the discrepancy with dental anesthesia rates and will address this next year when the MPRRAC looks at dental service rates.

Finally, advocates argue that if budget constraints require providers to earn less from serving Medicaid patients, there should be some equity in the discount across providers. The Department did not directly address the question, but the argument begs the question of equity compared to what standard. Compared to the benchmark of Medicare rates selected by the Department's analysis, anesthesia rates are overly favorable and the Department would need to reduce anesthesia rates to achieve greater equity in the discount across providers. Even the proposed solution is arguably overgenerous, if the goal is equity in the discount across providers, since most providers receive something less than the Medicare benchmark.

In FY 2015-16, after years of hearing complaints from providers about the inadequacy of anesthesia rates, the JBC recommended, and the General Assembly approved, an increase for anesthesia services of $12.9 million total funds, including $4.3 million General Fund. In the same year, the JBC sponsored, and the General Assembly passed, S.B. 15-228 to require the Department, with input from the Medicaid Provider Rate Review Advisory Committee (MPRRAC), to analyze and review provider rates on a five-year schedule. The S.B. 15-228 review was designed so that the General Assembly could make decisions about rates based on data and the recommendations of a stakeholder panel with knowledge of the delivery system, rather than the cries of the loudest lobbyists. The anesthesia request follows the Department's recommendations from the S.B. 15-228 review.

ALTERNATIVE CARE FACILITIES

Because Medicare does not cover assisted living residences, the Department used other state Medicaid programs as a benchmark and found Colorado rates fall between 27.1 percent and 89.5 percent of the benchmark comparison state rates. In response to federal requirements, the Department recently

developed a new rate setting methodology for waiver services that identifies expected costs for salaries, facilities, administration, capital, and potentially other inputs identified through the stakeholder process, and then applies a budget neutrality factor to prevent an increase in costs when a waiver is renewed. The alternative care facility rates are 52.6 percent of the rate calculated via the Department's new rate setting methodology before the budget neutrality factor. Of the waiver service rates reviewed this year by the Department through the S.B. 15-228 process, the rates for alternative care facilities were among the lowest relative to both the benchmark comparison states and the Department's new rate setting methodology, and among the most commonly identified by stakeholders as problematic.

PHYSICIAN SERVICES AND SURGERY
For physician services and surgery the Department's analysis found:

- Medicaid payments do not differentiate based on the place of service as often as payments from other providers.
- The access analysis was inconclusive for a half dozen regions and services.
- Benchmark comparisons varied widely by service. As an example, the Department indicated one cardiology service payment was 26.37 percent of the benchmark while another was 200.64 percent of the benchmark.

The Department's proposed budget neutral rebalancing would better align Medicaid rates with the benchmark Medicare rates and prevent unintended incentives to increase or decrease utilization in certain locations or of certain services for which Medicaid pays significantly higher or lower than the benchmark. Although the rebalancing is designed to be budget neutral in total, staff notes that some providers may experience a net decrease or increase in payments. While the Department can attempt to minimize the disproportionate impacts by provider, it is impossible to avoid some providers winning and some providers losing with the proposed rebalancing.

NURSING FACILITY PER DIEM
Nursing home rates are exempt from review by the MPRRAC, because the Department adjusts the rates annually based on a statutory formula to the lesser of actual allowable costs or 3.0 percent growth in the General Fund. The Department explains that the request is to better align the increase for nursing facilities with the requested across-the-board increase for other providers and control the growth of Medicaid expenditures. Due to the confidentiality of the Governor's budget preparation process, the Department did not consult with stakeholders prior to the recommendation.

The staff recommendation to deny the request assumes that if the General Assembly wanted nursing home rates to be treated the same as other provider rates, then the General Assembly would not have codified a formula for calculating nursing home rates in statute. If the Department proposed permanently reworking the special statutory status of nursing home rates, because the statutory formula unfairly advantages nursing homes relative to other providers, then the JBC staff could understand the logic. However, the proposal in front of the JBC is for a one-year exception to the statutory rate formula, rather than an ongoing change. Why would the General Assembly make a one-year exception? Is the General Assembly only concerned about equity in FY 2018-19?

There is a precedent for a one-year exception to the nursing home rate formula. However, the exceptions occurred in years the General Assembly made major reductions statewide to balance the

budget with available revenues. Without a similar impetus this year, the JBC staff does not understand the rationale for a temporary exception to the statutory nursing home rate formula.

Underfunding 24/7 care or care to vulnerable populations is a recipe for abuse and neglect, which is presumably why the General Assembly decided to ensure adequate funding for nursing homes through a statutory rate formula. However, not all providers of 24/7 care or care to vulnerable populations receive annual statutory rate increases. The General Assembly has recently provided ad hoc increases for some of these other providers, including increases last year for private duty nursing, personal care and homemaker, and home health, but not all of them. In case it is helpful in evaluating the Department's request to reduce nursing home rates based on equity concerns, the table below compares recent increases in nursing home rates to the rate changes for other providers of 24/7 and in-home care.

Nursing Rates vs Other 24/7 Care and In-home Care					
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Cumulative Change
24/7 Care:					
Alternative Care Facilities - EBD and CMHS Waivers	2.0%	0.5%	0.0%	1.4%	3.9%
Private Duty Nursing - Registered Nursing	2.0%	10.2%	0.0%	1.4%	14.0%
Private Duty Nursing - Licensed Practical Nursing	2.0%	0.5%	0.0%	7.2%	9.9%
Regional Centers - ICF average per day	1.5%	0.6%	-2.4%	0.0%	-0.3%
Bethesda Lutheran - ICF average per day	9.5%	-3.9%	-2.5%	5.4%	8.1%
Mental Health Institutes average per day[1]	-5.5%	5.7%	4.5%	-	4.5%
Psychiatric Residential Treatment Facility	0.0%	0.5%	0.0%	1.4%	1.9%
In-Home Care:					
Personal Care and Homemaker	2.1%	10.7%	0.0%	3.1%	16.5%
Home Health - Home Health Aid Basic	2.0%	0.5%	0.0%	1.4%	3.9%
Home Health - RN/LPN & Therapies	2.0%	0.5%	0.0%	6.0%	8.7%
Nursing Facilities	3.0%	3.0%	3.0%	3.0%	12.6%

[1] Data for FY 17-18 is not yet available due to enrollment data issues in the new MMIS.

ACROSS-THE-BOARD RATE INCREASE

The staff recommendation during figure setting for community provider rates was for a 1.0 percent across-the-board increase for all eligible community providers, including those paid by the Department of Health Care Policy and Financing. Since the JBC has not yet adopted a common policy for community provider rates, the staff recommendation is pending. The amounts that appear in the summary tables and numbers pages are based on the Governor's request.

Once the JBC decides on a common policy, the JBC staff recommends applying it to a revised estimate of the eligible base using the Department's February 2018 forecast. For the divisions covered in this figure setting, the community provider rate adjustment applies to two line items. The table below summarizes the recommended revised base eligible for a common policy adjustment and the result of applying the Governor's requested increase to this base versus the JBC staff recommended common policy. In addition, there could be actions approved by the JBC that would need to be compounded by the common policy, but these are pending JBC decisions.

R9 Provider Rates - Eligible Base for Common Policy					
	Rate	Total Funds	General Fund	Cash Funds	Federal Funds
Medical Services Premiums		$4,145,118,377	$1,341,281,152	$166,620,817	$2,637,216,408
Local Public Health Agencies Transfer		728,178	364,089	0	364,089
TOTAL - Eligible Base		$4,145,846,555	$1,341,645,241	$166,620,817	$2,637,580,497
Governor's Requested Increase	0.77%	$31,923,018	$10,330,668	$1,282,980	$20,309,370
Staff Recommended Common Policy	1.00%	$41,458,465	$13,416,452	$1,666,208	$26,375,805

➔ R10 Drug cost containment initiatives

Request

The Department requests a net increase of $132,777 total funds, including a decrease of $24,407 General Fund, to implement new prior authorization review (PAR) requirements for physician-administered drugs and to explore alternative payment models for pharmaceuticals. The request includes increases for contract services to administer the PARs and to research the alternative payment models, and offsetting decreases due to projected changes in utilization as a result of the new PARs.

The request assumes the new PARs would be implemented January 2019, and so the administrative costs and savings roughly double in the second year.

The request includes funds for system changes because physician-administered drugs are billed and paid like an office visit, rather than through the pharmacy billing module. The Department sees a benefit in a pharmacy vendor reviewing the PAR requests. For a pharmacy vendor to review the PARs, the Department needs to adjust the interface between the billing system modules for office visits and pharmaceuticals. In addition, the Department is not currently able to track whether a member accessed a drug through the pharmacy benefit and the same drug through the medical benefit.

In addition to the fiscal impact of new PARs, the request includes funds to study alternative payment methods for drugs. Current federal policy requires states to cover all drugs in the national rebate program, but the Department indicates some of these drugs have limited proven clinical efficacy. An alternative payment model would adjust net payments for drugs (probably through adjustments to rebates) based on patient outcomes. The Department is also considering submitting a waiver request to allow the Department additional time in reviews before covering new drugs lacking proven clinical efficacy. The contract services would help the Department study the options and plan the best course. Statutory changes might be required in a future year to implement an alternative payment model.

Recommendation

Staff recommends the request, but assumes a lower savings from decreased utilization in FY 2019-20. This request is very similar to the portion of R8 proposing to implement new PARs for medical services, except it is targeted at pharmaceuticals. Many of the same staff concerns about providing adequate resources to implement the PARs carefully and not overestimating the savings apply to this request, as well.

For this request, the Department had more directly applicable data from other states to use in estimating the projected savings, which increases staff confidence in the projected savings. An analysis of West Virginia PARs on second-generation antipsychotic agents found a decrease in utilization of 13.9 percent, and in Iowa PARs reduced utilization 17.1 percent for antiarthritics, benzodiazepines,

antiulcer, and antihistamines. Many of these drugs overlap with the physician administered drugs the Department proposes targeting. Also, the Department explicitly accounted for the substitution affect of people using alternatives by reducing the assumed savings 50 percent from the West Virginia utilization experience.

However, the Department did not account for drug rebates. Absent information about the drug rebates for the specific targeted physician administered drugs, the JBC staff used the average drug rebate of 49 percent for all drugs in the pharmaceutical benefit to reduce the projected savings. The Department estimates there is typically a six month lag from utilization to when the Department receives payments for drug rebates, and so accounting for drug rebates does not affect the projected expenditures until FY 2019-20.

R10 Drug Cost Containment				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
FY 18-19				
PARs				
System costs	$665,500	$71,800	$0	$593,700
PAR reviews	247,297	61,824	0	185,473
Decreased utilization	(1,080,520)	(308,281)	(39,129)	(733,110)
Subtotal - PARs	*(167,723)*	*(174,657)*	*(39,129)*	*46,063*
Alternative Payment Model	300,500	150,250	0	150,250
TOTAL	**132,777**	**(24,407)**	**(39,129)**	**196,313**
FY 19-20				
PARs				
System costs	$0	$0	$0	$0
PAR reviews	512,599	128,150	0	384,449
Decreased utilization	(1,186,207)	(340,931)	(52,436)	(792,840)
Subtotal - PARs	*(673,608)*	*(212,781)*	*(52,436)*	*(408,391)*
Alternative Payment Model	300,500	150,250	0	150,250
TOTAL	**(373,108)**	**(62,531)**	**(52,436)**	**(258,141)**

➔ R12 CHILDREN'S HABILITATION TRANSFER

REQUEST

The Department requests $210,455 total funds, including $105,230 General Fund, and 1.8 FTE to enhance and transfer the Children's Habilitation Residential Program (CHRP), which provides treatment and out of home services for foster children with intellectual and developmental disabilities, from the Department of Human Services to the Department of Health Care Policy and Financing.

RECOMMENDATION

The recommendation reflects the JBC's decisions during figure setting for the Office of Community Living 2/27/18.

➔ R14 SAFETY NET PROGRAMS

REQUEST

The Department requests an increase of $81,324 total funds, with no net change in General Fund, to: (1) allow recoveries from the Senior Dental Program to be reallocated to serve more seniors; (2) allow additional tobacco tax revenues allocated to the Primary Care Fund for grants to be spent; and (3) finance audits of the Primary Care Fund and Colorado Indigent Care Program.

RECOMMENDATION

The staff recommendation is summarized in the table below and components of the request, the associated staff recommendations, and any differences from the request are discussed under the subheadings below.

R14 Safety Net Program			
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS
FY 18-19			
Senior Dental Program	$27,848	$0	$27,848
Primary Care Fund	668,404	0	668,404
Audits			
Professional Audit Contracts	135,500	28,864	106,636
Primary Care Fund Program	(53,160)	0	(53,160)
Clinic Based Indigent Care	(28,864)	(28,864)	0
Subtotal - Audits	*53,476*	*0*	*53,476*
TOTAL	**$749,728**	**$0**	**$749,728**
FY 19-20			
Senior Dental Program	$27,848	$0	$27,848
Primary Care Fund	0	0	0
Audits			
Professional Audit Contracts	203,860	40,187	163,673
Primary Care Fund Program	(53,160)	0	(53,160)
Clinic Based Indigent Care	(40,187)	(40,187)	0
Subtotal - Audits	*110,513*	*0*	*110,513*
TOTAL	**$138,361**	**$0**	**$138,361**

SENIOR DENTAL PROGRAM

The Department requests $27,848 spending authority from the Department of Health Care Policy and Financing Cash Fund to allow recoveries from the Senior Dental Program to be reallocated to grantees. This is a somewhat higher amount than actual recoveries in prior years to allow for variation in the recoveries from one year to the next. In addition, the Department requests that an "(I)" notation be added to the cash funds appropriation indicating that the money is for informational purposes only.

The Senior Dental Program is a General Fund grant program with no federal match that provides dental care for people 60 years and older with income below 250 percent of the federal poverty guidelines who are not eligible for Medicaid or the Old Age Pension State Medical Program and have no other dental insurance. Participating providers receive a grant allocation and then bill the Department by procedure up to the grant cap. Program monitoring and audits occasionally find billing errors, resulting in recoveries that are deposited in a generic catch-all fund called the Department of Health Care Policy and Financing Cash Fund.

Since S.B. 14-180 (Kefalas/Swalm) created the Senior Dental Program with the transfer of a predecessor program from the Department of Public Health and Environment, the General Assembly has appropriated $2,962,510 General Fund for the program. In FY 2016-17 the program served 2,734 seniors with an average of $1,083 per senior. In FY 2016-17 grantees reported there were 1,110 seniors on waiting lists with an estimated cost for services of $1,175,628. There were 12 counties with no grantees: Archuleta, Baca, Cheyenne, Dolores, Huerfano, Kiowa, La Plata, Las Animas, Montezuma, Ouray, Prowers, and San Juan.

Recommendation

Staff recommends the requested $27,848 spending authority from the Department of Health Care Policy and Financing Cash Fund, but not the requested "(I)" notation, and transferring all the funds for the Senior Dental Program to a new line item.

The Department appears to misunderstand the purpose and function of the "(I)" notation. Just attaching an "(I)" note to the line item would not allow the Department to spend whatever it wants. An "(I)" note indicates that an amount appearing in the Long Bill is NOT an appropriation and is included only for informational purposes. The "(I)" note is generally only used when a department is already authorized to spend the amount by another law, constitutional provision, or court interpretation. Attaching the "(I)" note to an amount from the Department of Health Care Policy and Financing Cash Fund would mean there is no appropriation from that fund. Since the Department of Health Care Policy and Financing Cash Fund is specifically subject to annual appropriation in the enabling statute[2], the "(I)" notation would mean the Department had no appropriation to spend the money.

For reference, the relevant portion of the headnotes to the Long Bill reads:

> ***SECTION 2.*** *(l)(1)(I) Where the letter "(I)" appears directly to the right of a figure or in a letternote referencing a figure, that amount is not an appropriation, nor does it limit the expenditure of such money. The figure is included for informational purposes only. I t provides a record of funds anticipated to be expended and, in some instances, may indicate assumptions used relative to those funds in developing appropriated amounts.*

The General Assembly could provide flexible spending authority from the Department of Health Care Policy and Financing Cash Fund by either changing the enabling statute for the fund, or adding a footnote. A footnote may set forth purposes, conditions (such as allowing the Department to spend more), or limitations on an item of appropriation, to the extent the purposes, conditions, or limitations are integral to the appropriation and not reserving to the General Assembly powers of close supervision.[3] However, in this case the JBC staff does not believe a statutory change or footnote is necessary or beneficial. If a balance accrues in the Department of Health Care Policy and Financing Cash Fund from a large recovery from the Senior Dental Program, the General Assembly could provide additional spending authority in a supplemental or in the next fiscal year.

On a side note, some advocates promote expanding the Senior Dental Program to reduce the waiting lists. In response to a JBC hearing question, the Department expressed a priority for expanding the program to the counties with no grantees over reducing the wait lists. Either way, the JBC staff notes

[2] Section 25.5-1-109, C.R.S.
[3] Section 24-75-112 (2)(a), C.R.S.

that current rates per procedure for the Senior Dental Program are significantly higher than Medicaid pays. In 2014 the Department estimated rates for the Senior Dental Program were on average 71 percent higher than equivalent Medicaid rates. Reducing the Senior Dental Program rates to match Medicaid rates could free up General Fund to expand the Senior Dental Program to more counties, reduce the wait lists, or address other budget priorities. The statute for the Senior Dental Program sets a minimum for the rates based on the predecessor program operated by the Department of Public Health and Environment, and so reducing the rates to match Medicaid rates would require a bill.

Another factor to consider is that the current format of the Senior Dental Program does not generate a federal match. If the Department could get a federal demonstration waiver for a new Medicaid dental-only benefit for seniors, then the program could generate a federal match, freeing up General Fund to expand the Senior Dental Program to more counties, reduce the wait lists, or address other budget priorities. It is not known if the federal Centers for Medicare and Medicaid Services (CMS) would approve a demonstration waiver for this purpose, but demonstrations for specific services for specific populations, such as family planning, have been approved previously for other states by previous federal administrations. The Department would most likely need to make a case that expanding dental services for higher income seniors positively affects overall health, wellbeing, and independence, and thereby the likelihood of future Medicaid expenditures.

Regarding the new line item, the current format of the Long Bill buries appropriations for the Senior Dental Program in the Old Age Pension State Medical Program line item. This made some sense for the predecessor program that served as the dental benefit for people in the Old Age Pension State Medical Program, but not for the current incarnation of the Senior Dental Program that provides grants. Therefore, to improve transparency the JBC staff recommends a dedicated line item for the Senior Dental Program.

PRIMARY CARE FUND

The Department requests flexibility to spend all revenues received by the Primary Care Fund in a given year, and to accomplish this proposes an "(I)" notation to the appropriation indicating that the money is for informational purposes only. Statutes annually transfer 19 percent of tobacco tax revenues to the Primary Care Fund for distribution to qualified primary care providers that serve patients regardless of their ability to pay.[4] Distributions to providers are based on the number of medically indigent clients served. There is no federal match for these distributions. The annual appropriation is made based on a forecast of tobacco tax revenues that may not match actual revenues. In addition, expenditures from the Primary Care Fund for administrative costs may not match exactly to the appropriation. For these reasons, the Primary Care Fund has accumulated, over time, an ending balance. In FY 2016-17 that ending balance was $668,404.

Recommendation

Staff recommends an additional $668,404 cash funds one-time spending authority to spend down the FY 2016-17 ending balance in the Primary Care Fund that was not requested by the Department, and not the requested "(I)" notation. As described during the discussion of the Senior Dental Program above, just attaching an "(I)" note to the line item would not allow the Department to spend whatever it wants. The Department would need spending authority from another source, such as a statute or Constitutional provision, to spend the money. The enabling statute for the Primary Care Fund indicates that it is subject to annual appropriation. The General Assembly can provide authority to

[4] Section 24-22-117 (2)(b), C.R.S.

spend down the fund balance in the Primary Care Fund by simply increasing the appropriation in the Long Bill or a supplemental bill. No separate bill is necessary. If the General Assembly wants to use the available balance in the Primary Care Fund for a different purpose, it would require a bill.

AUDITS

The Department requests $135,500 total funds, including $28,864 General Fund, for additional audits of the Primary Care Fund and Colorado Indigent Care Program. Some of the money would be moved from line items that support the Primary Care Fund and Colorado Indigent Care Program respectively, and some would come from projected new revenue to the Healthcare Affordability and Sustainability (HAS) Fee Fund that would otherwise go to the Colorado Indigent Care Program or other allowable uses of the HAS Fee. In FY 2015-16 the General Assembly approved $50,000 for annual audits of the Primary Care Fund, but the Department indicates the audits found multiple data validation issues, suggesting a need for more intensive audits. Some of the findings include providers not applying the sliding fee schedules properly, not correctly identifying the medically indigent population, and not maintaining records. Inaccurate reporting by a provider can change the allocation of the Primary Care Fund and negatively affect other providers. For the Colorado Indigent Care Program, providers that receive more than $1,000,000 annually currently hire independent auditors, resulting in inconsistent interpretations of program rules and requirements. Also, handling multiple independent audits has proved administratively burdensome for both the Department and providers. Instead, the Department proposes a uniform state-administered audit of the Colorado Indigent Care Program, which the Department indicates is supported by the stakeholders.

Recommendation

Staff recommends the request. Improving accountability to program rules and requirements for both the Primary Care Fund and Colorado Indigent Care Program will ensure clients are receiving the intended level of service, and ensure funds are distributed to providers in the intended proportions.

➔ R15 CHASE ADMINISTRATION

REQUEST

The Department requests an increase of $1.2 million total funds, including $596,132 from the Healthcare Affordability and Sustainability (HAS) Fee Cash Fund, for 11 new staff positions (10.1 FTE in the first year) to support the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), legal services to defend the enterprise, data analytics consulting services, and software licensing. Senate Bill 17-267 replaced the Hospital Provider Fee with the HAS Fee and designated the HAS Fee as an enterprise exempt from the limits of the Taxpayer's Bill of Rights (TABOR).

The Department argues that S.B. 17-267 added new responsibilities for the Department to provide business services to the hospitals, including:

- Consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness
- Advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid
- Providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program
- Providing funding for a healthcare Delivery System Reform Incentive Payments (DSRIP) program

In addition to financing these new duties, the Department's request includes funds to improve oversight of the collection and distribution of the provider fee, properly account for enterprise activities, and defend the enterprise against legal challenges.

Regarding the legal challenges, existing litigation predating the creation of the CHASE, alleges the provider fee on hospitals is a tax and therefore subject to TABOR's requirement that a public vote be taken before it is levied or increased. The plaintiffs were recently granted a motion to amend their suit to include a challenge of the qualification of CHASE as an enterprise under TABOR. The plaintiffs seek a refund of all revenue collected, kept, or spent unconstitutionally, plus interest, since FY 2010-11. The requested funds represent a 50 percent increase in the CHASE legal services budget and would purchase roughly 1,290 hours of legal services. Since the request was submitted in November, discovery work has exceeded expectations and the Attorney General's Office indicates more resources might be needed, but no official request has been submitted. The requested legal services are related to the law suit and the Department does not anticipate a need for continued funding once the law suit is complete. A finding for the plaintiffs would disrupt the current financing method for Medicaid expansion populations and for supplemental payments to hospitals and would have significant General Fund and policy consequences.

RECOMMENDATION

Staff recommends a total of six new positions (5.4 FTE in the first year) for different purposes than the Department requested. All of the positions receive a 50 percent federal match with the state share from the HAS Fee.

The Department justifies most of the requested FTE as necessary to address the "new" responsibilities in S.B. 17-267 to provide business services to the hospitals. Of the "new" responsibilities, the only one identified by the Department in the fiscal note for S.B. 17-267 as potentially driving a fiscal impact was the Delivery System Reform Incentive Payments (DSRIP). The Legislative Council Staff Fiscal Note assumed the General Assembly would address contracts for consultant services for the development of the DSRIP through the annual budget process and did not include a cost estimate. The other "new" responsibilities were part of both the 2017 bill and the failed bill in 2016 to replace the Hospital Provider Fee with an enterprise, and so the Department failed to identify a fiscal impact associated with these "new" responsibilities two years in a row.

The JBC staff believes these are not "new" responsibilities, but descriptions of existing business services added to the statute in order to bolster the argument that CHASE is a government owned business, as required for enterprise status under TABOR. No testimony during debate on either the failed 2016 bill or the 2017 bill contemplated new responsibilities for the Department, other than DSRIP.

However, the JBC staff agrees the Department would benefit from additional resources to address some weaknesses in the Department's oversight of Medicaid expenditures for hospitals. First, S.B. 17-267 did assign the Department new duties to implement DSRIP. Second, the Department needs to improve the accuracy and credibility of the provider fee collection and distribution model. Negotiations over the collection and distribution model are high stakes for the hospitals, and if it is easy to discredit models based on data collection or calculation errors, or if communication is poor and the hospitals do not understand the models, then some hospitals could take advantage of the situation to the detriment of the state and/or other hospitals. Third, the state would benefit from

more in-house expertise regarding the drivers of hospital expenditures, particularly to explore why the cost shift is not decreasing as promised/expected when the provider fee was created.

The table below compares the staff recommendation to the Department's request. The position groupings were created by the JBC staff and may not match the way the Department would describe the positions. In some cases, JBC staff conversations with the Department yielded different descriptions of the intended purpose and function of each requested position than the limited text included in the November request.

It is important to note that while the General Assembly appropriates the funds for FTE, the executive branch makes the decisions about how to staff departments. The Department's actual hiring decisions could differ from the JBC staff recommendation. For example, if the Department feels that a contract manager for the HAS Fee Model Oversight is a critical position, it could prioritize hiring for that function over an auditor. The table describes the assumptions used to justify the staff recommendation for 6 new positions. It is not an attempt to dictate to the Department the specific positions the Department must fill.

R15 CHASE Administration		
	HCPF	JBC Staff
New Positions (includes operating)		
DSRIP		
Project Manager	$84,220	$0
Hospital Quality Administrator	56,194	56,194
Community Health Needs Analyst	56,194	56,194
Hospital Policy Administrator	56,194	0
HAS Fee Model Oversight		
Auditor	68,445	68,445
Rates and Financial Analyst	64,050	64,050
Contract Manager	56,194	0
Hospital Trend Analysis		
Rates and Financial Analyst	0	64,050
Rates and Financial Analyst	0	64,050
General Enterprise Management		
Budget Analyst	78,057	0
Accountant	56,194	0
Procurement and Contracts	49,392	0
Stakeholder Relations	49,392	0
Centrally-appropriated benefits	128,925	0
Subtotal - New Positions	*803,451*	*372,983*
Legal Services	123,811	123,811
Contract Services	250,000	250,000
Software Licenses	15,000	15,000
TOTAL	**$1,192,262**	**$761,794**
FTE	**10.1**	**5.4**
HAS Fee	596,132	380,898
Federal Funds	596,130	380,896

DSRIP

The LCS Fiscal Note for S.B. 17-267 assumed only contract consulting services would be needed to implement DSRIP, but to make payments based on performance metrics it is reasonable for the Department to request FTE. To ensure that the DSRIP quality metrics are consistent with existing standards and performance metrics used by other payers, the Department wants to make hospital compliance with the federal Community Health Needs Assessment a significant part of the program, and so one of the positions is described a specifically tied to this purpose. The Department also requested a project manager and hospital policy administrator, but 4.0 FTE is significantly beyond the scope of what the LCS Fiscal Note for S.B. 17-267 assumed, and so the JBC staff did not recommend these positions.

HAS FEE MODEL OVERSIGHT

To improve the Department's ability to accurately calculate the HAS Fee collection and disbursement model, the JBC staff recommends an auditor and a rates and financial analyst. The Department also requested a contract manager, because the Department uses the services of several vendors in developing the model and wants mover oversight in validating that the analysis by the vendors is accurate and consistent with the intent of the Department. The staff recommendation prioritizes developing the Department's in-house expertise over continued or increased reliance on vendors for the HAS Fee calculations.

HOSPITAL TREND ANALYSIS

To contain Medicaid expenditures effectively, the JBC staff believes the Department needs more resources to analyze hospital costs. Hospitals are a significant driver of public and private insurance expenditures. The Department estimates just under 30 percent of Medicaid expenditures are for hospitals. An analysis by the Division of Insurance estimates that for private insurers the payments to hospitals represent an even larger share of total payments, at roughly 42 percent in 2015. The Department did not specifically request any staff to analyze hospital costs. Additional analysis by the Department could potentially lead to initiatives that improve the healthcare delivery system to the benefit of all users and insurers, rather than just Medicaid.

In addition, the Department needs staff to investigate why the Medicaid payment to hospital cost ratio is not improving. When the General Assembly first authorized a provider fee for hospitals in H.B. 09-1293, hospital administrators testified that it would reduce the cost shift from Medicaid to private insurance, thereby containing private insurance costs. Implementing the Medicaid eligibility expansion under the Affordable Care Act increased the amount the Department could pay hospitals through the provider fee far and above anything contemplated when the General Assembly adopted H.B. 09-1293. At the same time, care provided by hospitals to the uninsured decreased dramatically, likely due to the combination of the Medicaid eligibility expansion, federal tax credits for buying insurance through the healthcare exchange, and the individual mandate in the ACA to purchase health insurance or pay a tax penalty. Despite these changes, hospitals report that the payment to cost ratio for private insurance has increased, and a cost shift from Medicaid to private insurance continues.

Payment to Hospital Cost Ratio								
Insurer	2009	2010	2011	2012	2013	2014	2015	2016
Medicare	0.80	0.76	0.77	0.74	0.64	0.71	0.72	0.71
Medicaid	0.54	0.74	0.76	0.79	0.80	0.72	0.75	0.71
Insurance	1.55	1.49	1.54	1.54	1.52	1.59	1.58	1.64
CICP/Self/Other	0.52	0.72	0.65	0.67	0.84	0.93	1.11	1.07
Overall	1.05	1.06	1.07	1.07	1.05	1.07	1.08	1.09

GENERAL ENTERPRISE MANAGEMENT

The JBC staff characterizes several positions requested by the Department as for general enterprise management and does not recommend these positions. For example, the Department requested an accountant because the enterprise requires "clear distinction" in its fiscal operations from the Department. If the Department believes a dedicated accountant is necessary to operate an enterprise, then this should have been a cost identified in the Department's fiscal analysis of S.B. 17-267. The JBC staff does not agree that a dedicated accountant is necessary, noting that other departments that manage enterprises, like the Department of Revenue or the Department of Natural Resources, did not add accountants specifically to manage the enterprises. If the Department is concerned about portions of time that various existing accounting staff spend supporting the enterprise, the Department could reorganize the existing accounting staff to create a dedicated position, rather than adding a new position. The JBC staff concerns about the other positions are similar. Nothing in S.B. 17-267 drove a need for an additional budget analyst, procurements and contracts specialist, or stakeholder relations specialist. Nor are these positions critical for supporting the recommended staff for DSRIP, HAS Fee model oversight, or hospital trend analysis.

➔ R16 EMERGENCY TRANSPORT CPE

REQUEST

The Department requests a net increase of $18.6 million total funds, including a decrease of $710,560 General Fund, to take funds spent by local governments on emergency medical transportation (EMT) and certify those funds as public expenditures in order to claim an estimated $9.5 million in matching federal funds through Medicaid. The Department will use a portion of the increased revenue to offset General Fund costs for administration, similar to the process used for other certified public expenditures, and the bulk to increase reimbursements for public EMT providers by an estimated $8.6 million.

In FY 2018-19 and beyond the Department estimates a need for $668,294 total funds, including $334,147 General Fund, for on-going technical assistance to the Department and providers in completing the necessary federal documentation. With the requested funding, the Department anticipates it could claim an additional $9,547,069 federal funds through Medicaid in FY 2018-19 and beyond. The Department proposes using 10 percent ($954,707) of the increased federal revenue to offset General Fund costs for the Department and distributing the remaining $8,592,362 to the publicly financed EMT providers with expenses eligible for a federal match.

R16 Emergency Transport CPE				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
FY 2017-18:				
Contract services	$180,000	$90,000	$0	$90,000
FY 2018-19:				
Contract services	668,294	334,147	0	334,147
Eligible local expenditures	19,094,138	0	9,547,069	9,547,069
General Fund offset	(954,707)	(954,707)	0	0
TOTAL FY 2018-19	**$18,807,725**	**($620,560)**	**$9,547,069**	**$9,881,216**
Incremental Change	$18,627,725	($710,560)	$9,547,069	$9,791,216

Net Benefit to Providers	
Eligible local expenditures	$19,094,138
Local contribution	(9,547,069)
General Fund offset	(954,707)
Net Benefit	**$8,592,362**

The proposed 10 percent General Fund offset is consistent with what the General Assembly has previously approved for certified public expenditure financing of hospitals, physician services, and Denver Health ambulance payments. However, there are examples of certified public expenditure financing with different General Fund offsets. For Public School Health Services the General Fund offset is equal to actual administrative costs per statute. For nursing facility and home health services 100 percent of the federal funds earned from certified public expenditures is used to offset the General Fund, with no increase in payments to providers.

The proposal benefits only publicly financed EMT providers with eligible expenses who complete the administratively burdensome federal documentation process. Of the 188 EMT providers enrolled in Medicaid, 102 (54.3 percent) identified as governmental/public providers that might have eligible expenses. The share of total costs eligible for certification will vary based on the level of government support.

The Medicaid Provider Rate Review Advisory Committee (MPRRAC) analyzed EMT rates before the FY 2017-18 budget cycle and found Colorado Medicaid reimbursements for emergency and nonemergency medical transportation were significantly below the benchmark, based on Medicare's ambulance fee schedule and Medicaid fee schedules for Alabama, Alaska, Arkansas, California, Connecticut, Montana, Nebraska, New Mexico, North Dakota, and Wisconsin. The Department concluded that EMT rates are sufficient to allow for client access and provider retention, because providers cannot refuse service to clients, but noted that despite access sufficiency the rates may not reflect appropriate reimbursement for high-value services. The Department did not recommend a change in rates last year, but committed to:

- Gather information on surrounding state rates;
- Investigate supplemental funding (similar to the Hospital Provider Fee or Nursing Provider Fee) for EMT services;
- Calculate the fiscal impact of opening "treat and release" codes;
- Investigate if changes to regulations could lesson potentially-avoidable utilization of EMT services;

- Gather more information from EMT providers on the rate components they consider inadequate; and
- Forecast budgetary impacts of a rate increase for existing EMT services.

This request follows the Department's investigation of supplemental funding opportunities for EMT services.

RECOMMENDATION

Staff recommends approval of the request. The JBC previously approved a supplemental for FY 2017-18 for $180,000 total funds, including $90,000 General Fund, for contract services to help plan the program and develop the necessary State Plan Amendment. The proposed financing will not help all EMT providers, and the request does not close the benchmark gap identified by the MPRRAC, but it offers a way to improve EMT rates without requiring additional General Fund (in fact it saves some General Fund).

If the JBC wants to do more for EMT rates and/or address the NEMT rates that the MPRRAC also identified as below the benchmark, then the tables below might be helpful. At the request of the JBC staff, the Department provided a revised estimate of what it would cost to get to 100 percent of the 2015 benchmark identified by the MPRRAC, using current utilization assumptions and accounting for a rate increase provided by the General Assembly last year. The first table estimates the cost to match the benchmark. The effect by rate would vary, but the total dollar increase required would be 130.7 percent more than the base. This does not include the requested CPE for EMT.

Cost to Increase Rates to 100% of 2015 Benchmark			
	EMT/NEMT Combined	EMT	NEMT
Total Funds	**$73,719,214**	**$41,042,010**	**$32,677,204**
General Fund	22,323,604	10,019,427	12,304,177
Cash Funds	5,483,897	1,449,477	4,034,420
Federal Funds	45,911,713	29,573,106	16,338,607

The next table summarizes the amounts required for each 1.0 percent increase in EMT and NEMT rates.

Each 1.0 Percent Increase			
	EMT/NEMT Combined	EMT	NEMT
Total Funds	**$516,960**	**$196,198**	**$320,762**
General Fund	168,676	47,897	120,779
Cash Funds	46,531	6,929	39,602
Federal Funds	301,753	141,372	160,381

➔ R17 SINGLE ASSESSMENT TOOL

REQUEST

The Department requests adjustments to shift funding for a single assessment tool for intellectual and developmental disabilities, authorized by S.B. 16-192, to future years. The change to the timeline does not change total projected expenditures over the life of the project. The Department also requests roll forward authority for project funds.

RECOMMENDATION

The recommendation reflects the JBC's decisions during figure setting for the Office of Community Living 2/27/18.

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. The sources of cash funds and reappropriated funds reflect the Department's financing as a whole and the programs supported by the FTE in the division. The largest source of cash funds for the division is the Hospital Provider Fee.

EXECUTIVE DIRECTOR'S OFFICE						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 Appropriation						
SB 17-254 (Long Bill)	$278,481,375	$61,369,366	$35,954,741	$4,149,782	$177,007,486	417.7
HB 18-1161 (Supplemental Bill)	12,026,005	525,138	4,644,441	43,776	6,812,650	0.8
Other legislation	508,781	133,162	121,228	0	254,391	0.7
TOTAL	**$291,016,161**	**$62,027,666**	**$40,720,410**	**$4,193,558**	**$184,074,527**	**419.2**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$291,016,161	$62,027,666	$40,720,410	$4,193,558	$184,074,527	419.2
R6 Home care visit verification	2,364,610	548,842	0	0	1,815,768	6.9
R7 Community transition services	0	0	0	0	0	0.0
R8 Medicaid savings initiatives	2,840,053	689,074	133,342	4,151	2,013,486	5.9
R9 Provider rates - Across-the-board	7,210	3,605	0	0	3,605	0.0
R10 Drug cost containment	1,213,297	283,874	0	0	929,423	0.0
R11 Administrative contracts	1,539,236	1,162,564	831,237	0	(454,565)	0.0
R12 Children's habilitation transfer	210,455	105,229	0	0	105,226	1.8
R13 All-payer claims database	(500,000)	(500,000)	0	0	0	0.0
R14 Safety net programs	135,500	28,864	106,636	0	0	0.0
R15 CHASE administration	761,794	0	380,898	0	380,896	5.4
R16 Emergency transport CPE	488,294	244,147	0	0	244,147	0.0
R17 Single assessment tool	(4,872,225)	(2,324,518)	0	0	(2,547,707)	0.0
R18 Cost allocation	366,400	120,050	63,150	0	183,200	0.0
R19 IDD waiver consolidation	478,500	239,250	0	0	239,250	0.0
BA11 County administration	0	0	0	0	0	0.0
BA12 Public school health services	0	0	0	0	0	0.0
BA14 Benefits utilization system	230,040	115,020	0	0	115,020	0.0
NP CBMS-PEAK	467,661	500,178	(267,342)	1,501	233,324	0.0
NP Risk management cybersecurity	3,766	1,883	0	0	1,883	0.0
NP OIT HCPF security	(84,054)	(23,184)	(18,843)	0	(42,027)	0.0
Staff initiated - veterans outreach	25,000	12,500	0	0	12,500	0.0
Centrally appropriated items	2,762,278	718,730	(3,470)	237,600	1,809,418	0.0
Transfers to other agencies	170,882	70,040	0	0	100,842	0.0
Annualize prior year budget actions	(10,843,700)	2,256,302	(729,156)	89,854	(12,460,700)	9.0
TOTAL	**$288,781,158**	**$66,280,116**	**$41,216,862**	**$4,526,664**	**$176,757,516**	**448.2**
INCREASE/(DECREASE)	**($2,235,003)**	**$4,252,450**	**$496,452**	**$333,106**	**($7,317,011)**	**29.0**
Percentage Change	(0.8%)	6.9%	1.2%	7.9%	(4.0%)	6.9%
FY 2018-19 EXECUTIVE REQUEST	**$287,645,633**	**$69,017,849**	**$37,325,544**	**$4,526,664**	**$176,775,576**	**454.7**
Request Above/(Below) Recommendation	($1,135,525)	$2,737,733	($3,891,318)	$0	$18,060	6.5

DECISION ITEMS - EXECUTIVE DIRECTOR'S OFFICE

➔ HAS ADMINISTRATIVE COSTS

Senate Bill 17-267 stipulates that the, "administrative costs of the [Healthcare Affordability and Sustainability] Enterprise are limited to three percent of the Enterprise's expenditures based on a methodology approved by the Office of State Planning and Budgeting and the staff or the Joint Budget Committee of the General Assembly."[5] The OSPB and JBC staff agree that the terms "administrative costs" and "the Enterprise's expenditures" include spending from all fund sources, including federal funds, and are not limited to just spending from the Healthcare Affordability and Sustainability (HAS) Fee. This is important because the favorable federal match rates for services financed with the HAS Fee compared to administrative costs financed with the HAS Fee can make the percentage spent on administration look different by fund source. The table below illustrates the issue using FY 2016-17 actual expenditures from the Hospital Provider Fee.

FY 2016-17 Hospital Provider Fee Percent for Administration

	Total Funds	Provider Fee	Federal Funds
Administration	$59,519,570	$20,602,739	$38,916,831
Total Expenditures	$2,905,027,901	$652,245,346	$2,252,782,555
Percent for Administration	2.0%	3.2%	1.7%

To calculate administrative costs, the OSPB and JBC staff include all expenses in the Executive Director's Office, plus expenditures for the Children's Basic Health Plan Administration in the Indigent Care Program division. OSPB and the JBC staff do not include in "administrative costs" expenses for the Accountable Care Collaborative. The federal government considers expenditures for the Accountable Care Collaborative as something other than services for purposes of determining whether they qualify for the enhanced federal match rate for Affordable Care Act expansion populations.

For FY 2018-19, the Department's November 1 request, including all decision items, would result in administrative costs representing just under 2.1 percent of total expenditures. The final percentage may change based on the JBC's actions and on actual Medicaid and CHP+ enrollment and expenditures. While OSPB and the JBC staff are responsible for developing a methodology to calculate administrative costs as a percentage of total expenditures, the Enterprise is responsible for ensuring administrative costs do not exceed the statutory limit. The statute does not describe any penalties for noncompliance.

Since the request year percentage will always be a moving target, the JBC staff does not plan to update the estimated percentage for every JBC action, unless there is reason to believe the Department is close to the limit. Instead, the JBC staff will focus on monitoring actual administrative costs as a percent of total expenditures and report any violations of the statutory limit to the JBC. If there is a violation of the percentage limit on administrative costs, the JBC can decide on a reasonable response for the next fiscal year.

[5] Section 25.5-4-402.4 (4)(a)(III), C.R.S.

➔ R11 ADMINISTRATIVE CONTRACTS

REQUEST

The Department requests $1.5 million total funds, including $1.2 million General Fund, to update funding for two administrative contracts and pay a federal disallowance. First, the Department requests $234,9540 total funds, including $117,477 General Fund, because bids to implement a federally-required electronic asset verification program for Medicaid applicants came in higher than projected, and the Department has a revised estimate of the caseload. Second, the Department requests a net $0 total funds change, but a decrease of $259,195 General Fund, for a decrease in the federal match rate for quality reviews of prepaid inpatient health plans that is offset by an allocation of a portion of the state share of costs to the Healthcare Affordability and Sustainability (HAS) Fee. Third, the Department requests $1,304,282 General Fund for a one-time payment of a federal disallowance based on claiming too high a federal match rate for quality reviews of the Accountable Care Collaborative in prior years. The Department is contesting the federal disallowance and would submit a supplemental to reduce funding if the challenge is successful.

RECOMMENDATION

Staff recommends approval of the requested technical true-ups.

R11 Administrative Contracts

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS
Asset verification system	$234,954	$117,477	$0	$117,477
Quality reviews	0	(259,195)	831,237	(572,042)
Disallowance	1,304,282	1,304,282	0	0
TOTAL	**$1,539,236**	**$1,162,564**	**$831,237**	**($454,565)**

➔ R13 ALL-PAYER CLAIMS DATABASE

REQUEST

The Department requests $2.8 million total funds, including $1.7 million General Fund, and 1.8 FTE to support operations of the All-Payer Claims Database (APCD). The APCD collects claims data from 21 private insurance providers in Colorado plus Medicaid and Medicare and makes it available for research. The request includes three components:

- $2,050,000 total funds, including $1,025,000 General Fund, to pay Medicaid's share of APCD administrative costs, based on Medicaid claims representing 41.0 percent of the APCD;
- $218,558 total funds, including $109,280 General Fund, and 1.8 FTE for the federal cost accounting required to reimburse the APCD through Medicaid, to administer the contract, and to provide staff support to the advisory committee; and
- $550,000 General Fund for a direct payment to the APCD to make up a projected shortfall in funding due to expiring private grants.

Researchers use the APCD to investigate the reasons behind rising health care costs, the variance of health care costs within Colorado, and to find possible solutions. The APCD does not directly provide information about patient diagnoses or health outcomes, but researchers can use claims histories indirectly to draw conclusions about best practices and cost-effective care. The statewide information about claims available through the APCD is not available anywhere else.

Some examples of the uses of the APCD include:

- Best practices -- The APCD can provide quality indicators like the rates of hospitalization for patients that received certain billed preventive interventions. A number of statewide initiatives to improve care, including the Comprehensive Primary Care Plus (CPC+), the Multi-payer Collaborative, and the State Innovation Model (SIM), use the APCD in ways like this to facilitate performance-based payments and encourage practice transformation. The Department uses the APCD to calculate utilization of potentially avoidable procedures by hospital for use in the development of hospital report cards. The Network for Regional Healthcare Improvement used the APCD to provide reports to provider groups comparing their costs and efficiency to broader averages.
- Access to care -- The Department uses data from the APCD to compare utilization by payer to help determine whether Medicaid rates and practices allow Medicaid patients to access care consistent with patients insured by other payers, as required by federal law.
- Rate setting -- The Department uses the APCD to identify appropriate benchmarks and measure Medicaid rates against those benchmarks.
- Cost of care by payer -- The Department uses analysis from the APCD to calculate total cost of care by payer group: Medicare, Medicaid, and commercial. The National Bureau of Economic Research is using the APCD to explore how Medicare rates affect commercial insurance rates.
- Cost of care by region -- For the Colorado Commission on Affordable Health Care, the Department and the Division of Insurance used the APCD to analyze the current nine geographic regions that determine insurance rates against other potential configurations, and to analyze factors driving variations in health care costs by region.

The Department projects an FY 2018-19 operating cost for the APCD of $5.0 million and revenue of $2.4 million from selling limited datasets and reports, leaving a funding gap of $2.6 million. In prior years, the APCD received private grants for startup costs, but at the end of FY 2017-18 a grant from the Colorado Health Foundation expires. Other states have successfully claimed federal matching funds through Medicaid for the administration of their versions of the APCD. With Medicaid claims representing 41 percent of the APCD, the Department estimates Medicaid administrative payments could provide $2,050,000 for the APCD, with $1,025,000 from the General Fund and $1,025,000 from matching federal funds. The Department proposes that the remaining $550,000 funding gap would be closed with a General Fund only grant to the APCD.

Pursuant to Section 25.5-1-204 (11), C.R.S., if funding is insufficient to finance the ongoing operations of the APCD, then the APCD shall cease to exist and the data submitted shall be destroyed or returned to the original source.

There are 18 states with a legislatively mandated APCD and these states use a variety of financing methods:

Type of Funding	# of States	% of Total
A. All State funded (including contributions from state agencies)	5	27.8%
B. Medicaid Match and/or Contribution	7	38.9%
C. Grants	2	11.1%
D. State Appropriations and assessments	4	22.2%
Total	18	100.0%

RECOMMENDATION

Staff recommends:

- The **JBC sponsor legislation** (item #11 on the JBC's list of potential legislation) to provide financing for the APCD, rather than the requested appropriation in the Long Bill, based on feedback from Legislative Legal Services about the need for legislation.
- The JBC remove $500,000 General Fund included in the Long Bill in prior years for a scholarship program to use the APCD, and instead provide the funding and new statutory authorization in the proposed bill.
- The JBC reduce the total funding for the APCD from the Department's request by the $550,000 General Fund that the Department had proposed for the purpose of backfilling expiring private grants.
- The JBC reduce the new staff for the Department from the Department's request by 1.0 FTE.

More detail about the rationale for each component of the recommendation is provided under the subheadings below.

NEED FOR LEGISLATION

House Bill 10-1330 (Kefalas & Kagan/Morse) authorized the creation of the All-Payer Claims Database with gifts, grants, and donations. Section 25.5-1-204, C.R.S., reads

> *If sufficient funding is received through gifts, grants, and donations on or before January 1, 2012, as determined by the executive director, the administrator shall, in consultation with the advisory committee, create the Colorado all-payer claims database.*

The Department's request to begin funding the program with a combination of Medicaid money and a direct General Fund appropriation appears to conflict with separate statutory guidance that prohibits the use of General Fund for a program previously financed solely with gifts, grants, and donations. Section 24-75-1305 (1), C.R.S., states:

> *. . . the general assembly shall not make an appropriation of moneys from the general fund or from any other source of state moneys to fund a program, service, study, or other function of state government that was previously funded through grant moneys and that has not received adequate grant moneys to support the program, service, study, or other function of state government for the applicable fiscal year.*

The Department's request anticipated this legal concern and argues that Section 24-75-1305 (1), C.R.S. does not apply, because the entity that received the grants the Department now wants to backfill was the operator of the APCD, a nonprofit called the Center for Improving Value in Health Care (CIVHC), and not a state agency.

However, Legislative Legal Services' analysis concludes that the relevant state agency is the Department of Health Care Policy and Financing, which received a gift or donation of services from CIVHC to operate the APCD. Therefore, Section 24-75-1305 (1), C.R.S., applies. If the JBC wants to provide General Fund for the APCD, LLS recommends authorizing legislation separate from the Long Bill.

This component of the staff recommendation would allow the General Assembly to provide funding for the APCD beyond gifts, grants, and donations, and would not otherwise change the operations of the APCD.

SCHOLARSHIP PROGRAM

The Joint Budget Committee created the scholarship program with an appropriation in the FY 2014-15 Long Bill and has provided $500,000 General Fund for the scholarships every year since. However, there is no specific authorizing legislation for a scholarship program, or statutory guidance with criteria for how the money should be awarded. The appropriation could be viewed as making substantive law in the Long Bill and should be removed.

Some of the scholarships awarded appear questionable to the JBC staff. For example, the Department, which administers the money, has granted some of the scholarship funds back to the Department. When a grantor is also an eligible grantee, it creates a conflict of interest, or at least the appearance of one. Also, the Department has granted scholarships to other state agencies. Typically, state agencies pay for research using operating funds, or come to the General Assembly with a request for special funding and a justification for the necessity and cost of the research. The scholarship program created a pot of money that any state agency could access and put the Department in charge of deciding who gets funding. Finally, the Department has made grants to out-of-state researchers working on national projects. The Department's self-created grant criteria[6] gives a preference to Colorado researchers, but allows out-of-state researchers to apply for projects that the Department deems to benefit Coloradoans. The JBC staff cannot determine whether these types of scholarships are consistent with what the JBC intended when the JBC created the program, because there is no authorizing legislation and there was very limited public debate.

The only legislative guidance available on the purpose of the scholarships is the footnote that accompanies the appropriation. The scholarships that appear questionable to the JBC staff do not violate the limited guidance in the footnote:

> 11 *Department of Health Care Policy and Financing, Executive Director's Office, General Administration, Scholarships for Research Using the All-Payer Claims Database -- The purpose of this appropriation is to provide scholarships for nonprofit and governmental entities to defray the cost of access to the All-Payer Claims Database to conduct research.*

A list of the scholarships awarded in FY 2016-17 and as of November in FY 2017-18 is provided as an appendix at the end of this figure setting document.

Assuming that the JBC wants the scholarship program to continue, then staff recommends the JBC develop guidelines for the grant program and put the guidelines in statute. The JBC staff recommends a ban on scholarships to state departments. Clarifying language could be added to allow professors at state funded higher education institutions to apply, if the JBC wants to allow them. However, if the JBC wants state departments, including HCPF, to be able to apply for scholarships, then the JBC staff recommends putting a third party, such as the APCD advisory committee, in charge of awarding the funds to prevent a conflict of interest.

[6] http://www.civhc.org/wp-content/uploads/2017/08/CO-APCD-Scholarship-Information-FY18.pdf

REDUCE FUNDING

The APCD has proven valuable to state policy analysis, and so providing some state support for the APCD makes sense, but the JBC staff believes the Department has not exhausted all other potential options than the General Fund for closing the funding gap. For example, other insurance providers, besides Medicaid, benefit directly or indirectly from the APCD, and this could justify a subscription fee. The goals of the APCD are aligned with those of many private philanthropic organizations, such as the Colorado Health Foundation or the Kaiser Family Foundation, and the APCD could seek additional grant funds. The APCD could increase charges for reports and datasets. Finally, the APCD could reduce operating expenses.

The budget for the APCD has increased every fiscal year since it was created:

APCD Budget		
	Millions	% Inc.
FY 14-15	$2.7	
FY 15-16	$3.8	40.7%
FY 16-17	$4.4	15.8%
FY 17-18	$4.9	11.4%
FY 18-19	$5.0	2.0%

In a hearing response, the Department provided this explanation for the increased costs:

> *In late 2015 through early 2016, CIVHC [the operator of the APCD] implemented key strategies to strengthen APCD data, including additional quality assurance, adding self-insured and dental claims, and increasing data management. In 2017, CIVHC transitioned to a new data vendor, migrated from quarterly to monthly data updates, enhanced the data portal access, website, and public reporting capabilities, as well as new customer tools. The increased activities and transition to a new vendor have increased the costs related to the administration of the APCD starting in FY 2016-17 and ongoing when compared to the FY 2015-16 budget reported in the 2016 APCD Annual Report. The transition has also increased the data accuracy and improved analytics.*

The JBC staff understands the value of improving the quality, breadth, and currency of APCD data, and making it easier to access the data, but the APCD increased expenditures to make these improvements without a sustainable funding stream. The 2016 APCD annual report indicates the transition to the new data vendor, new reporting capabilities, and processing enhancements were all funded with reserves. The JBC staff is not sure why the APCD would spend down reserves with grant funding expiring at the end of FY 2017-18 and no confirmed method for financing the APCD in the future. The APCD had a functioning database that got from point A to B and traded it in for a faster one with more features right before the financing payments were due and the APCD needed to ask the legislature for help.

In a hearing response, the Department indicated:

> *The intent of the funders who have provided grant funding to the APCD (including CHF [the Colorado Health Foundation]) was to support the start-up of the database, and was never intended to provide perpetual*

> *ongoing support. . . Since the launch of the APCD, the Colorado Health Foundation and others have openly communicated that the APCD would need a revenue base and diversified funding, allowing the funders to redirect community dollars to other community needs and innovations within Colorado.*

This suggests the time-limited nature of the grant funding was never in doubt for the administrators of the APCD,[7] but the APCD proceeded with costly enhancements anyway. If the APCD is not able to raise money from additional fees or grants, then maybe the APCD could scale back on some of these enhancements to live within the available funds.

While staff does not recommend the requested direct General Fund grant to the APCD, the JBC staff is recommending the requested Medicaid financing. It is strange to measure the fair share of costs for Medicaid based on the percentage of claims in the database contributed by Medicaid, rather than the value Medicaid draws from the database, but this method for drawing federal matching funds has been approved for other states. For the future, the JBC staff thinks the Department should explore whether some of the costs should be allocated to the HAS Fee in proportion to HAS Fee claims. For now, the proposed Medicaid financing is an efficient way to provide more benefit for the APCD with less General Fund.

LESS STAFF FOR HCPF

Staff recommends one fewer FTE for the Department than the request, and an adjustment to the estimated cost of the FTE to account for the JBC's common policy regarding first year benefits. Using Medicaid funds to finance the APCD requires significant additional cost accounting and some additional regulatory oversight. This function would be performed by the requested and recommended contract administrator. However, the Department also requested a program manager to staff the advisory committee, ensure data submissions are timely and conform to APCD standards, verify that Medicaid data released by the APCD adheres to federal data use requirements, and assist in pursing grants for the APCD. These functions were not part of the original fiscal note for the bill authorizing the APCD. The Department previously absorbed these costs within existing resources and can continue to do so.

SUMMARY

The table below summarizes the dollar changes recommended by the JBC staff.

R13 APCD					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Long Bill					
Scholarship for Using the APCD	($500,000)	($500,000)	$0	$0	0.0
APCD Bill					
Cost accounting staff	82,737	41,369	0	41,368	0.9
Medicaid share of APCD	2,500,000	1,250,000	0	1,250,000	
Scholarship for Using the APCD	500,000	500,000	0	0	-
Subtotal	*$3,082,737*	*$1,791,369*	*$0*	*$1,291,368*	*0.9*
TOTAL	**$2,582,737**	**$1,291,369**	**$0**	**$1,291,368**	**0.9**

[7] This is strangely incongruous with the authorizing legislation that contemplated the APCD would be financed exclusively from gifts, grants, and donations.

➔ R18 COST ALLOCATION

REQUEST

The Department requests $366,400 total funds, including $120,050 General Fund, to increase contract services that assist in complying with federal cost allocation procedures necessary to claim federal matching funds for administrative functions, especially those performed by vendors that may have costs that are not eligible for Medicaid reimbursement.

The Department contracts with several vendors for administrative functions and many of these vendors have multiple lines of business that must be kept separate to ensure Medicaid administrative payments do not pay for unrelated costs. The federal Centers for Medicare and Medicaid Services (CMS) periodically reviews the cost allocation methodologies used for different vendors and the documentation of expenditures and can retroactively disallow federal payments that would need to be repaid.

The cost allocation contractor would develop allocation methodologies and justification of how they comply with federal standards, assist with calculations from vendor cost reports based on the methodologies, and help ensure appropriate documentation to avoid federal disallowances. The contractor would ensure that administrative payments do not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, that payments not include overhead related to operating a provider facility, that payments not duplicate payments for activities that are already offered or should be provided by other entities or paid through other programs, that payments do not supplant funding obligations from other federal sources, and that costs are supported by adequate documentation.

The Department identified an initial need for cost allocation work related to the eligibility and enrollment vendor, Connect for Health Colorado, and Denver Health Medical Assistance sites, as well as future needs related to the other Medical Assistance sites, the Single Entry Points, Community Centered Boards, Aging and Disability Resource Centers, and various vendors related to the Health Insurance Exchange/Health Information Technology initiative.

In addition to developing and maintaining the cost allocation methodologies, the request includes funds for periodic audits of vendors that use complex allocation methodologies relying on Random Moment Time Studies (RMTS). In recent negotiations on time allocation methodologies, CMS has begun adding requirements for audits of RMTS. The audits ensure the time studies are performed correctly, the data and results are valid, training requirements are met, and documentation is maintained. The request assumes 600 hours of work developing and maintaining cost allocation methodologies and 122 hours of work performing audits of RMTS.

The Department proposes hiring a vendor that does work with Medicaid programs nationally, rather than doing the work in-house, so Colorado can benefit from a better understanding of what cost allocation methodologies have been approved for other states, and the pros and cons of the available options.

RECOMMENDATION
Staff recommends approval of the request. The funding will ensure both state and federal expenditures for administrative contracts are appropriate, and reduce the potential for federal disallowances that would need to be repaid by the state.

➔ R19 IDD WAIVER CONSOLIDATION

REQUEST
The Department requests $478,500 total funds, including $239,250 General Fund, for two years of contract services for additional work identified as necessary to complete the consolidation of Home- and Community-Based Services waivers for adults with intellectual and developmental disabilities as directed by H.B. 15-1318.

RECOMMENDATION
The JBC tabled this item during figure setting for the Office of Community Living 2/27/18. The numbers in the table reflect the Governor's request and will be updated when the JBC makes a decision.

➔ BA11 COUNTY ADMINISTRATION

REQUEST
The Department submitted BA11 to continue and annualize a supplemental S11 that consolidated funding for county administration.

RECOMMENDATION
Staff recommends the requested continuation of the JBC's supplemental action to consolidate funding for county administration.

➔ BA14 BENEFITS UTILIZATION SYSTEM

REQUEST
The Department requests $230,040 total funds, including $115,020 General Fund, to temporarily extend support for the Business Utilization System (BUS) that manages client assessments and determines eligibility for long-term services and supports programs. The BUS is being replaced by a new module in the Department's Medicaid Management Information System billing software, but user testing revealed the new module will not be ready for implementation in FY 2018-19 as originally scheduled. In addition, the Department wants to spend more time training case managers for the new module, as it has new functions and works in significantly different ways than the legacy system. The requested funding will pay for service and support through the Office of Information Technology for one more fiscal year.

RECOMMENDATION
Staff recommends approval of the request to extend support for this mission critical information technology system until the new module is ready for implementation.

➔ NP CBMS-PEAK

REQUEST
The Department requests funding for increasing costs of the Colorado Benefits Management System (CBMS) that determines eligibility for Medicaid and other public assistance programs. The funds would address producing and mailing client correspondence, meeting federal security requirements, and covering the software license, maintenance, and support costs associated with existing capacity and performance issues.

RECOMMENDATION
The recommendation reflects the JBC's decisions during figure setting for the Governor's Office of Information Technology 2/12/18.

➔ NP OIT HCPF SECURITY

REQUEST
The Department requests funding for transfer to the Governor's Office of Information Technology to address information technology security issues within the Department.

RECOMMENDATION
The recommendation reflects the JBC's decisions during figure setting for the Governor's Office of Information Technology 2/12/18.

➔ NP RISK MANAGEMENT CYBERSECURITY

REQUEST
The Department requests an adjustment to payments for risk management to address cybersecurity issues.

RECOMMENDATION
The JBC tabled this item during figure setting for the Governor's Office of Information Technology 2/12/18. The numbers in the table reflect the Governor's request and will be updated when the JBC makes a decision.

➔ STAFF INITIATED – TRANSFERS TO LOCAL PUBLIC HEALTH AGENCIES "(M)" NOTE

Last year the JBC approved moving $360,484 General Fund from the Department of Public Health and Environment to the Department of Health Care Policy and Financing with the understanding that the money would be matched by federal Medicaid funds and sent back to the Department of Public Health and Environment for Local Public Health Agencies. The Local Public Health Agencies would spend the money to coordinate with the Regional Accountability Entities (RAEs) to help them address population health issues affecting Medicaid clients and thereby reduce Medicaid costs. When the appropriation was made, an "(M)" note was attached to the line item to designate that if the federal funds increase or decrease the General Fund is reduced.

RECOMMENDATION
Staff recommends a supplemental adjustment to remove the "(M)" note from the line item. The Department indicates that the federal Centers for Medicare and Medicaid Services (CMS) has not yet approved the financing. If CMS approval is not provided during the fiscal year, the "(M)" note would trigger a reduction in the General Fund, resulting in a loss of money for the Local Public Health Agencies (LPHAs). The original intent of the JBC was to leverage existing General Fund money for the Local Public Health Agencies with federal funds to expand services, and not to cut funding for the LPHAs should federal funding not materialize. Thus, the "(M)" note appears inconsistent with the JBC's original intent.

➔ STAFF INITIATED – VETERANS OUTREACH

During figure setting for the Department of Military and Veterans Affairs, the JBC approved a new Request for Information asking the two departments to explore opportunities for improved outreach to connect veterans with available federal and state services, which could improve veteran health outcomes and reduce Medicaid expenditures. In conjunction with the new Request for Information, the JBC also approved $25,000 total funds, including $12,500 General Fund, for contract services for the Department of Health Care Policy and Financing.

RECOMMENDATION
The JBC staff calculations include the $25,000 previously approved by the JBC for researching outreach to veterans. The text of the approved Request for Information is as follows:

C Department of Health Care Policy and Financing, Executive Director's Office; and Department of Military Affairs, Executive Director and Army National Guard -- The Departments are requested to explore the potential for comparing Medicaid, veterans services, and other data sources to identify individuals who might benefit from enrolling in or expanding their use of federal Veterans Administration (VA) benefits. The Departments are requested to submit a report by November 1, 2018, addressing the following questions.

- Based on Public Assistance Reporting Information System (PARIS) data matching, how many veterans are dually enrolled in Medicaid and VA benefits in Colorado? What are the Medicaid expenditures for such dually enrolled individuals, and what share of this is supported with state funds? Provide a comparison of the most significant Medicaid service expenditures being made on behalf of these individuals and the services available through the VA. Based on this review, do the Departments believe that a significant number of dually enrolled individuals could make better use of VA services than they do presently? Based on available Colorado data and the experience of other states, do the Departments believe that assisting or encouraging a targeted group of individuals to access specific additional VA services is likely to yield service benefits to the individuals and/or financial benefits to the State? Provide an analysis of the costs and financial and other benefits the State might achieve from such an initiative. If the data indicate that benefits would outweigh the costs, include recommendations for next steps for achieving these savings. For example, should the State implement a pilot program? If so, in which department?

- How can the State identify veterans who are accessing state supported benefits such as Medicaid but who are **not** enrolled for federal veterans benefits? Can the State cross-check

its enrollees with federal databases that identify former service members/ former service members known to reside in Colorado? Is relevant information about veteran status currently collected in the Colorado Benefits Management System (CBMS) or could such information be collected? What do the Departments see as the benefits versus risks associated with adding a question to CBMS about whether an applicant formerly served in the U.S. Military? Have any other states successfully launched initiatives to mine federal data or use their own benefits enrollment systems to identify veterans who may be eligible for federal benefits but who have not enrolled? If so, how have they used this data and what has been the impact?

LINE ITEM DETAIL — EXECUTIVE DIRECTOR'S OFFICE

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, employee-related expenses and benefits, operating expenses, and general contract services. This subdivision also contains funding for all of the centrally appropriated line items in the Department.

STATUTORY AUTHORITY: Section 25.5-1-104 et. seq., C.R.S.

CENTRALLY APPROPRIATED LINE ITEMS SET BY JBC COMMON POLICY

The majority of line items in this subdivision are centralized appropriations that the JBC sets through common policies. In most cases the common policy allocates costs to agencies for a centralized service based on prior year actual utilization of that service by the department. Rather than discussing the staff recommendation for each line item individually, this section deals with all the line items set through JBC common policies at once. Line items that are not set by common policy are discussed individually following this section. This grouping of the staff recommendations on line items that are set through common policies is intended to simplify the narrative, but it does cause the descriptions of some line items to appear in an order that is different than the order in the numbers pages and in the Long Bill.

REQUEST: The Department requests:

- Annualizations of prior year bills and budget actions
- Application of the OSPB common policies
- Benefits associated with the new FTE requested in R6, R8, R12, and R15
- An increase to defend the CHASE enterprise in R15
- A nonprioritized request for the risk management property fund
- A nonprioritized request for the operating system and Microsoft office productivity suite

RECOMMENDATION: Staff recommends application of the JBC's common policies for the centralized appropriations described in the table below, including the way benefits for new FTE are handled. Note that the JBC's common policy was pending for some of the line items at the time this document was prepared. The amounts included in the numbers pages and department and division summary tables for the pending items are based on the request and will be updated to reflect the JBC's actions.

Health, Life, and Dental
Short-term Disability
Amortization Equalization Disbursement
Supplemental AED
Salary Survey
Merit Pay
Workers' Compensation
Legal Services
Administrative Law Judge Services
CORE Operations
Payment to Risk Management and Property
Capitol Complex Leased Space
Payments to OIT

The amount for legal services also includes an increase to defend the CHASE enterprise as described in the recommendation on R15.

PERSONAL SERVICES

This line item contains all of the personal services for the Department's employees, including employee salaries and the employer contributions to PERA and Medicare taxes. The line item also includes funding for temporary employees, employee buy-outs, and some contract services. However, most of the Department's professional contract service costs are contained in separate line items.

REQUEST: The Department requests:

- Funding associated with new FTE requested in R6, R8, R12, R13 and R15
- Annualizations of prior year bills and budget actions

STAFF RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail. In addition to the items requested by the Department, the JBC staff recommendation includes an adjustment to the fund sources to account for the increase in statewide indirect cost recoveries available to offset the need for General Fund for the line item, which appears in the centrally appropriated line items adjustment.

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, PERSONAL SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$30,835,001	$10,496,280	$2,977,177	$1,885,978	$15,475,566	417.7
HB 18-1161 (Supplemental Bill)	$52,218	$5,222	$0	$0	$46,996	0.8
Other legislation	$49,153	$16,569	$8,007	$0	$24,577	0.7
TOTAL	**$30,936,372**	**$10,518,071**	**$2,985,184**	**$1,885,978**	**$15,547,139**	**419.2**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$30,936,372	$10,518,071	$2,985,184	$1,885,978	$15,547,139	419.2
Annualize prior year budget actions	1,155,940	483,610	60,699	129,644	481,987	9.0
R6 Home care visit verification	440,884	106,394	0	0	334,490	6.9
R8 Medicaid savings initiatives	392,250	180,217	15,908	0	196,125	5.9
R15 CHASE administration	339,065	0	169,533	0	169,532	5.4
R12 Children's habilitation transfer	141,876	70,938	0	0	70,938	1.8
R13 All-payer claims database	0	0	0	0	0	0.0
Centrally appropriated items	0	(227,035)	0	227,035	0	0.0
TOTAL	**$33,406,387**	**$11,132,195**	**$3,231,324**	**$2,242,657**	**$16,800,211**	**448.2**
INCREASE/(DECREASE)	**$2,470,015**	**$614,124**	**$246,140**	**$356,679**	**$1,253,072**	**29.0**
Percentage Change	8.0%	5.8%	8.2%	18.9%	8.1%	6.9%
FY 2018-19 EXECUTIVE REQUEST	**$33,845,196**	**$11,220,283**	**$3,364,209**	**$2,242,657**	**$17,018,047**	**454.7**
Request Above/(Below) Recommendation	$438,809	$88,088	$132,885	$0	$217,836	6.5

OPERATING EXPENSES

This line item pays for operating expenses associated with the staff at the Department. Examples of the expenditures include software/licenses, office supplies, office equipment, utilities, printing, and travel.

Request: The Department requests:

- Funding associated with new FTE requested in R6, R8, R12, R13 and R15
- Annualizations of prior year bills and budget actions

STAFF RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$2,138,565	$953,811	$70,266	$26,219	$1,088,269	0.0
HB 18-1161 (Supplemental Bill)	$28,265	$2,826	$0	$0	$25,439	0.0
Other legislation	$23,964	$8,078	$3,904	$0	$11,982	0.0
TOTAL	**$2,190,794**	**$964,715**	**$74,170**	**$26,219**	**$1,125,690**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$2,190,794	$964,715	$74,170	$26,219	$1,125,690	0.0
R15 CHASE administration	48,918	0	24,459	0	24,459	0.0

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, OPERATING EXPENSES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
R8 Medicaid savings initiatives	38,526	17,369	1,895	0	19,262	0.0
R12 Children's habilitation transfer	10,270	5,135	0	0	5,135	0.0
R6 Home care visit verification	2,180	6,501	0	0	(4,321)	0.0
R13 All-payer claims database	0	0	0	0	0	0.0
Annualize prior year budget actions	(79,845)	(12,894)	(3,651)	(12,922)	(50,378)	0.0
TOTAL	**$2,210,843**	**$980,826**	**$96,873**	**$13,297**	**$1,119,847**	**0.0**
INCREASE/(DECREASE)	**$20,049**	**$16,111**	**$22,703**	**($12,922)**	**($5,843)**	**0.0**
Percentage Change	0.9%	1.7%	30.6%	(49.3%)	(0.5%)	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$2,235,351**	**$985,761**	**$103,505**	**$13,297**	**$1,132,788**	**0.0**
Request Above/(Below) Recommendation	$24,508	$4,935	$6,632	$0	$12,941	0.0

LEASE SPACE

This line item pays for the Department's leased space at 225 E. 16th Street and 303 E. 17th Ave.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding based on the lease costs.

SCHOLARSHIPS FOR RESEARCH USING THE ALL-PAYER CLAIMS DATABASE

This line item provides scholarships for nonprofit and governmental entities to defray the cost of access to the All-Payer Claims Database to conduct research.

REQUEST: The Department requests continuation funding of $500,000.

RECOMMENDATION: Staff recommends eliminating funding, as described in the recommendation regarding R13 All-payer claims database.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item pays for contract services used by the Department for special projects authorized by the General Assembly. The sources of cash funds include the Hospital Provider Fee, Nursing Facility Fee, Nursing Home Penalties, and the IDD Services Cash Fund. The federal match rate varies based on the specific contracts.

REQUEST: The Department requests several adjustments to contract services in R7, R10, R111, R12, R15, R16, R17, R18, and R19.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items and the staff initiated adjustment for veterans outreach for more detail.

EXECUTIVE DIRECTOR'S OFFICE, GENERAL ADMINISTRATION, GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$9,087,649	$2,934,405	$1,509,062	$150,000	$4,494,182	0.0
Other legislation	$325,000	$71,210	$91,290	$0	$162,500	0.0
HB 18-1161 (Supplemental Bill)	(752,078)	(376,039)	0	0	(376,039)	0.0
TOTAL	**$8,660,571**	**$2,629,576**	**$1,600,352**	**$150,000**	**$4,280,643**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$8,660,571	$2,629,576	$1,600,352	$150,000	$4,280,643	0.0
Annualize prior year budget actions	5,121,558	2,616,091	(55,312)	0	2,560,779	0.0
R16 Emergency transport CPE	488,294	244,147	0	0	244,147	0.0
R19 IDD waiver consolidation	478,500	239,250	0	0	239,250	0.0
R18 Cost allocation	340,780	111,656	58,734	0	170,390	0.0
R10 Drug cost containment	300,500	150,250	0	0	150,250	0.0
R15 CHASE administration	250,000	0	125,000	0	125,000	0.0
R11 Administrative contracts	234,954	117,477	0	0	117,477	0.0
R12 Children's habilitation transfer	29,500	14,750	0	0	14,750	0.0
Staff initiated - veterans outreach	25,000	12,500	0	0	12,500	0.0
R7 Community transition services	0	0	0	0	0	0.0
R17 Single assessment tool	(4,593,240)	(2,296,620)	0	0	(2,296,620)	0.0
TOTAL	**$11,336,417**	**$3,839,077**	**$1,728,774**	**$150,000**	**$5,618,566**	**0.0**
INCREASE/(DECREASE)	**$2,675,846**	**$1,209,501**	**$128,422**	**$0**	**$1,337,923**	**0.0**
Percentage Change	30.9%	46.0%	8.0%	0.0%	31.3%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$11,872,661**	**$4,107,199**	**$1,728,774**	**$150,000**	**$5,886,688**	**0.0**
Request Above/(Below) Recommendation	$536,244	$268,122	$0	$0	$268,122	0.0

(B) TRANSFERS TO OTHER DEPARTMENTS

PUBLIC HEALTH AND ENVIRONMENT

FACILITY SURVEY AND CERTIFICATION

This line item pays the Department of Public Health and Environment to monitor a variety of long-term care providers for safety and compliance with Medicaid regulations, including nursing homes, hospices, home health agencies, alternative care facilities, personal care/homemaking agencies, and adult day services. This monitoring is performed as part of the Department of Public Health and Environment's larger function of establishing and enforcing standards of operation for health care facilities. Financing for the Medicaid-related regulation is provided as follows:

Minimum Data Set resident assessment (used to determine nursing home patient acuity, which is a consideration in the nursing home reimbursement formula)	100% General Fund
In-the-field surveys and inspections	75% federal match
Office time preparing reports and administering the program	50% federal match

REQUEST: The Department requests annualizations of prior year budget decisions and nonprioritized adjustments for decision items submitted by the Department of Public Health and Environment.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

PRENATAL STATISTICAL INFORMATION

This line item pays the Department of Public Health and Environment to collect and analyze data, through the Vital Statistics office, on the effectiveness of the Enhanced Prenatal Care program, more commonly known as Prenatal Plus. This program provides case management, nutrition, and mental health counseling for women assessed as at-risk for delivering low birth weight infants. The services address lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect pregnancy. Services are paid for in the Medical Services Premiums line item. This appropriation covers only the data collection and evaluation performed by the Department of Public Health and Environment. The federal match rate is 50 percent.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

LOCAL PUBLIC HEALTH AGENCIES

This line item pays local public health agencies for Medicaid-eligible services in support and in coordination with the Regional Accountable Entities that operate the Accountable Care Collaborative.

REQUEST: The Department requests nonprioritized adjustments for decision items submitted by the Department of Public Health and Environment..

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Public Health and Environment. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the DPHE funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

HUMAN SERVICES

NURSE HOME VISITOR PROGRAM

This line item pays a portion of the cost for nurses to visit first-time mothers in families with incomes up to 200 percent of the federal poverty guidelines to provide education on nutrition and general child care and to promote the health and development of children. Funding for the program is appropriated to the Department of Human Services and then a portion is transferred to the Department of Health Care Policy and Financing to match federal funds for Medicaid-eligible clients. The original source of funding is Tobacco Master Settlement Agreement moneys. Although the Department of Human Services is the lead agency for financing, the program is actually administered by the University of

Colorado Health Sciences Center. The federal match rate is at the standard FMAP for Medicaid services.

STATUTORY AUTHORITY: Section 25-31-102, C.R.S.

REQUEST: The Department requests continuation funding.

Recommendation: Staff recommends the requested continuation funding. Based on prior year actual expenditures, this is probably more spending authority than the line item needs, but if fewer Medicaid-eligible clients are served, then the Department of Human Services will transfer less to the Department of Health Care Policy and Financing and use the tobacco settlement monies instead to serve clients who are not eligible for Medicaid.

REGULATORY AGENCIES

NURSE AIDE CERTIFICATION

This line item pays for the Department of Regulatory Agencies to certify nurse aides working in facilities with Medicaid patients. The Department of Regulatory Agencies also receives payments from Medicare. The reappropriated funds are fees for background checks transferred from the Department of Regulatory Affairs. Only non-certified nurses are required to pay the fees. The federal match rate is 50 percent.

STATUTORY AUTHORITY: Section 12-38.1-101 et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding based on the JBC's actions during figure setting for the Department of Regulatory Agencies. The money is transferred to the Division of Registrations in the Department of Regulatory Agencies.

REVIEWS

This line item pays the Department of Regulatory Affairs to conduct sunset reviews of programs administered by the Department of Health Care Policy and Financing. The federal match rate depends on the program being reviewed.

STATUTORY AUTHORITY: Section 24-34-104, et seq., C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

REGULATION OF MEDICAID TRANSPORTATION PROVIDERS

This line item pays for limited regulation permits of Medicaid non-emergency transportation providers pursuant to H.B. 16-1097 (Coram & Moreno/Scott). Vehicle inspection costs are eligible for a 50 percent federal match, but other costs are 100 percent General Fund. The money received by the Public Utilities Commission is continuously appropriated.

STATUTORY AUTHORITY: Section 40-10.1-302(2)(b)(II), C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

EDUCATION

PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION
This line item offsets costs of the Department of Education for the Public School Health Services program. The program is jointly administered by the Department of Health Care Policy and Financing and the Department of Education. Pursuant to statute, up to 10 percent of the federal funds received for the program may be retained for administration and these moneys are allocated between the two departments according to an interagency agreement. The source of funding used to match the federal funds is certified public expenditures by school districts. Please see the line item "Public School Health Services" in the Other Medical Services division for a discussion of the projected certified public expenditures and a description of program costs.

STATUTORY AUTHORITY: Section 25.5-5-318, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Education. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the Department of Education funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

LOCAL AFFAIRS

HOME MODIFICATIONS BENEFIT ADMINISTRATION AND HOUSING ASSISTANCE PAYMENTS
This appropriation pays the Department of Local Affairs to administer the existing Medicaid home modifications benefit. In addition, the Department of Local Affairs assists clients of the Colorado Choice Transitions (CCT) program in acquiring housing. The federal match rate is 50 percent for administration.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends setting this line item based on the JBC's decisions regarding funding in the Department of Local Affairs. Some of those decisions were still pending at the time of this publication and staff requests permission to update the total when those decisions are finalized. Since components of the Department of Local Affairs funding are pending, the amount reflected in the numbers pages for this line item is the Department's request.

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

This line item pays for maintenance of the Medicaid Management Information System (MMIS) and the Web Portal. MMIS processes Medicaid claims, performs electronic prior authorization reviews for certain medical services, transmits data so that payments can be made to providers, and manages information about Medicaid beneficiaries and services. The Web Portal provides a front-end interface for providers to submit electronic information to MMIS, the Colorado Benefits Management System, and the Benefits Utilization System in a format that complies with the confidentiality standards of the federal Health Insurance Portability and Accountability Act (HIPAA).

The federal match rate depends on the activity being financed. For design, development, or installation of automated data systems in administration of the Medicaid program, states are eligible for a 90 percent federal match. The on-going maintenance of these systems receives a 75 percent federal match. Operating expenses included in the contract with the MMIS vendor that are not computer-related, such as mailing expenses, receive a 50 percent federal match. The MMIS also supports CHP+, which receives an 88 percent federal match. Many projects include a mix of all these activities with a resulting blended federal match rate that is specific to that project.

STATUTORY AUTHORITY: Section 25.5-4-204, C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and reprogramming of the billing system to implement R6, R7, R8, R10, R15, and R17.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$41,535,458	$5,918,099	$4,270,044	$11,808	$31,335,507	0.0
HB 18-1161 (Supplemental Bill)	$575,252	$57,525	$0	$0	$517,727	0.0
Other legislation	$110,664	$37,305	$18,027	$0	$55,332	0.0
TOTAL	**$42,221,374**	**$6,012,929**	**$4,288,071**	**$11,808**	**$31,908,566**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$42,221,374	$6,012,929	$4,288,071	$11,808	$31,908,566	0.0
R6 Home care visit verification	1,921,546	435,947	0	0	1,485,599	0.0
R10 Drug cost containment	630,500	63,050	0	0	567,450	0.0
Annualize prior year budget actions	342,555	24,502	157,341	(5,190)	165,902	0.0
R8 Medicaid savings initiatives	57,456	5,746	0	0	51,710	0.0
R7 Community transition services	0	0	0	0	0	0.0
R15 CHASE administration	0	0	0	0	0	0.0
R17 Single assessment tool	(278,985)	(27,898)	0	0	(251,087)	0.0
TOTAL	**$44,894,446**	**$6,514,276**	**$4,445,412**	**$6,618**	**$33,928,140**	**0.0**
INCREASE/(DECREASE)	**$2,673,072**	**$501,347**	**$157,341**	**($5,190)**	**$2,019,574**	**0.0**
Percentage Change	6.3%	8.3%	3.7%	(44.0%)	6.3%	0.0%

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MEDICAID MANAGEMENT INFORMATION SYSTEM MAINTENANCE AND PROJECTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2018-19 EXECUTIVE REQUEST	**$45,246,946**	**$6,548,026**	**$4,452,912**	**$6,618**	**$34,239,390**	**0.0**
Request Above/(Below) Recommendation	$352,500	$33,750	$7,500	$0	$311,250	0.0

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REPROCUREMENT CONTRACTED STAFF

This line items paid for contracted staff for the renewal of the Department's claims processing hardware and software. It ended in FY 2017-18.

STATUTORY AUTHORITY: Section 25.5-4-204, C.R.S.

REQUEST: The Department did not request funding.

RECOMMENDATION: Staff does not recommend funding.

MEDICAID MANAGEMENT INFORMATION SYSTEM REPROCUREMENT CONTRACTS

This line items pays for reprocruement contracts for the renewal of the Department's claims processing hardware and software.

REQUEST: The Department requests annualizations of prior year budget decisions.

RECOMMENDATION: Staff recommends the request based on the procurement schedule and expected expenditures for the contracts.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, MMIS REPROCUREMENT CONTRACTS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$18,546,779	$1,034,108	$875,342	$5,564	$16,631,765	0.0
Other legislation	$0	$0	$0	$0	$0	0.0
TOTAL	**$18,546,779**	**$1,034,108**	**$875,342**	**$5,564**	**$16,631,765**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$18,546,779	$1,034,108	$875,342	$5,564	$16,631,765	0.0
Annualize prior year budget actions	(18,541,215)	(1,034,108)	(875,342)	0	(16,631,765)	0.0
TOTAL	**$5,564**	**$0**	**$0**	**$5,564**	**$0**	**0.0**
INCREASE/(DECREASE)	**($18,541,215)**	**($1,034,108)**	**($875,342)**	**$0**	**($16,631,765)**	**0.0**
Percentage Change	(100.0%)	(100.0%)	(100.0%)	0.0%	(100.0%)	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$5,564**	**$0**	**$0**	**$5,564**	**$0**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

FRAUD DETECTION SOFTWARE CONTRACT

This line item pays for maintenance and upgrades of software that detects payment, utilization, and referral patterns that may be indicators of fraud, waste, or abuse. It also monitors compliance issues and statistics related to fraud investigative costs.

STATUTORY AUTHORITY: Section 25.5-4-301, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CBMS OPERATING AND CONTRACT EXPENSES

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

REQUEST: The Department requests annualizations of prior year budget decisions and adjustments for implementing R8 and the non-prioritized CBMS-Peak request.

RECOMMENDATION: Staff recommends the requested adjustments based on the JBC's decisions during figure setting for the Governor's Office of Information Technology.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, OPERATING AND CONTRACT EXPENSES

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$23,549,140	$5,219,684	$3,453,935	$57,566	$14,817,955	0.0
HB 18-1161 (Supplemental Bill)	$4,742,605	$681,825	$412,362	$31,390	$3,617,028	0.0
Other legislation	$0	$0	$0	$0	$0	0.0
TOTAL	**$28,291,745**	**$5,901,509**	**$3,866,297**	**$88,956**	**$18,434,983**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$28,291,745	$5,901,509	$3,866,297	$88,956	$18,434,983	0.0
R8 Medicaid savings initiatives	1,309,206	225,088	115,539	4,151	964,428	0.0
NP CBMS-PEAK	467,661	496,624	(263,787)	1,501	233,323	0.0
Annualize prior year budget actions	0	(35,969)	35,969	0	0	0.0
TOTAL	**$30,068,612**	**$6,587,252**	**$3,754,018**	**$94,608**	**$19,632,734**	**0.0**
INCREASE/(DECREASE)	**$1,776,867**	**$685,743**	**($112,279)**	**$5,652**	**$1,197,751**	**0.0**
Percentage Change	6.3%	11.6%	(2.9%)	6.4%	6.5%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$30,068,611**	**$6,587,252**	**$3,754,018**	**$94,608**	**$19,632,733**	**0.0**
Request Above/(Below) Recommendation	($1)	$0	$0	$0	($1)	0.0

CBMS HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

This line item pays for operating and contract expenses associated with the Colorado Benefits Management System (CBMS).

REQUEST: The Department requests an adjustment for implementing the non-prioritized CBMS-Peak request

RECOMMENDATION: Staff recommends the request based on the JBC's decisions during figure setting for the Governor's Office of Information Technology.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, COLORADO BENEFITS MANAGEMENT SYSTEMS, HEALTH CARE AND ECONOMIC SECURITY STAFF DEVELOPMENT CENTER

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$684,816	$245,329	$95,921	$1,719	$341,847	0.0
HB 18-1161 (Supplemental Bill)	$320,599	$66,932	$92,398	$1,508	$159,761	0.0
Other legislation	$0	$0	$0	$0	$0	0.0
TOTAL	**$1,005,415**	**$312,261**	**$188,319**	**$3,227**	**$501,608**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$1,005,415	$312,261	$188,319	$3,227	$501,608	0.0
NP CBMS-PEAK	0	3,554	(3,555)	0	1	0.0
TOTAL	**$1,005,415**	**$315,815**	**$184,764**	**$3,227**	**$501,609**	**0.0**
INCREASE/(DECREASE)	**$0**	**$3,554**	**($3,555)**	**$0**	**$1**	**0.0**
Percentage Change	0.0%	1.1%	(1.9%)	0.0%	0.0%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$1,005,415**	**$315,815**	**$184,764**	**$3,227**	**$501,609**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	$0	0.0

HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS

This line item funds Medicaid's participation in the Health Information Exchange (HIE) network that allows the sharing of health data between providers.

Request: The Department requests annualizations of prior year budget decisions

Recommendation: Staff recommends the requested funding based on the previously approved development and maintenance schedule for the Health Information Exchange.

EXECUTIVE DIRECTOR'S OFFICE, INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS, HEALTH INFORMATION EXCHANGE MAINTENANCE AND PROJECTS				
	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION				
SB 17-254 (Long Bill)	$8,072,455	$1,891,246	$6,181,209	0.0
TOTAL	**$8,072,455**	**$1,891,246**	**$6,181,209**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION				
FY 2017-18 Appropriation	$8,072,455	$1,891,246	$6,181,209	0.0
Annualize prior year budget actions	(125,070)	63,548	(188,618)	0.0
TOTAL	**$7,947,385**	**$1,954,794**	**$5,992,591**	**0.0**
INCREASE/(DECREASE)	**($125,070)**	**$63,548**	**($188,618)**	**0.0**
Percentage Change	(1.5%)	3.4%	(3.1%)	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$7,947,385**	**$1,954,794**	**$5,992,591**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	0.0

CONNECT FOR HEALTH COLORADO SYSTEMS

This line item reimburses Connect for Health for eligibility determination assistance provided to applicants for Medicaid and the Children's Basic Health Plan.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: The JBC staff recommends the requested continuation funding.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

Funding in this line item pays for production of authorization cards for Medicaid and the Old Age Pension State Medical Program. The source of cash funds is the Hospital Provider Fee. The source of reappropriated funds is a transfer from the Old Age Pension Medical Program in the Other Medical Services division. The federal match rate is 50.0 percent for Medicaid cards. There is no federal match for the Old Age Pension State Medical Program.

STATUTORY AUTHORITY: Section 25.5-4-102, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding. The number of cards required each year is dependent not only on caseload, but also turnover. Periodically the Department will submit requests to update the estimate based on changing patterns in the number of cards needed, but not typically every year.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item pays for disability determination services, nursing home preadmission and resident assessments, and hospital outstationing. A fairly involved disability determination is required by federal law for all people who qualify for Medicaid due to a disability. Nursing home preadmission and resident assessments are also required by federal law to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. Hospital outstationing provides on-site services to inform, educate, and assist eligible clients in gaining Medicaid enrollment as part of efforts in the Health Care Affordability Act (H.B. 09-1293) to increase access and reduce undercompensated care. The funding in H.B. 09-1293 for outstationing was based on 1.0 FTE per hospital. The sources of cash funds are the Hospital Provider Fee and Colorado Autism Treatment Cash Fund.

STATUTORY AUTHORITY: Sections 25.5-4-105, 25.5-6-104, 25.5-4-205, and 25.5-4-402.3, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding based on the ongoing eligibility determination requirements and outstationing costs.

COUNTY ADMINISTRATION

This line item supports county eligibility determinations for Medicaid, the Children's Basic Health Plan, and the Old Age Pension State Medical Program. Funds are distributed to counties based on random moment sampling to determine caseload. At one point there was an expectation that counties contribute 20 percent toward the total, but over the years the legislature has approved initiatives without requiring an increase in county matching funds and the federal government has increased the federal match rate. The traditional federal match was 50 percent, but a recent reinterpretation by the Centers for Medicare and Medicaid Services (CMS) expanded the activities eligible for a 75 percent match as maintenance and operations of eligibility determination systems. There are no matching federal funds for eligibility determinations for the Old Age Pension State Medical Program.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding for this on-going need.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item was created to separate the funding for eligibility determinations for expansion populations authorized through the Health Care Affordability Act (H.B. 09-1293) from the funding for other populations. The state match for eligibility determinations for the expansion populations authorized by H.B. 09-1293 is funded entirely with the Hospital Provider Fee with no local county match. Through a supplemental in FY 2017-18 the funding in this line item was moved to the County Administration line item.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests no funding.

RECOMMENDATION: Staff recommends no funding.

ADMINISTRATIVE CASE MANAGEMENT

This line item provides Medicaid funding for qualifying expenditures associated with state supervision and county administration of programs that protect and care for children (out-of-home placement, subsidized adoptions, child care, and burial reimbursements). The primary activity reimbursed through this line item is completing, or assisting a child or family in the child welfare system to complete, a Medicaid application. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-1-120 through 122, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

MEDICAL ASSISTANCE SITES

This line item pays Medical Assistance sites for their work in processing applications.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CUSTOMER OUTREACH

This line item provides funding for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT Program) and for the Enrollment Broker Program. The EPSDT Program provides outreach and case management services to promote access to health care services for children. The enrollment broker program provides information to newly eligible Medicaid clients regarding their Medicaid Health Care Plan choices. Both of these programs are required by federal law and regulations. The source of cash funds is the Hospital Provider Fee. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-5-102 (1) (g) and 25.5-5-406 (1) (a) (II), C.R.S.

REQUEST: The Department requests annualizations of prior year budget actions.

RECOMMENDATION: Staff recommends the requested funding, including the annualizations of prior year budget decisions.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT

This line item pays a contractor to process applications and determine eligibility for the Children's Basic Health Plan (CHP+). It also includes money for determining Medicaid eligibility for adults without dependent children and the Medicaid buy-in for people with disabilities. The source of cash funds is the Hospital Provider Fee. The federal match rate varies based on the type of work and the population served. In order to qualify for CHP+ an applicant must be ineligible for Medicaid, and the majority of the processing time for CHP+ applications is actually spent determining Medicaid eligibility. For populations that are "newly eligible" pursuant to the ACA the match rate is higher.

STATUTORY AUTHORITY: Section 25.5-4-102, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

CONNECT FOR HEALTH COLORADO ELIGIBILITY DETERMINATIONS

This line item reimburses Connect for Health for eligibility determination assistance provided to applicants for Medicaid and the Children's Basic Health Plan.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

This line item contains the professional contracts related to reviewing acute care utilization, long-term care utilization, external quality review, drug utilization review, and mental health quality review. These contracts ensure that the benefits and services provided to Medicaid clients are medically necessary and appropriate.

Acute care utilization performs prior authorization review for services such as transplants, out-of-state elective admissions, inpatient mental health services, inpatient substance abuse rehabilitation, durable medical equipment, non-emergent medical transportation, home health service reviews, and physical and occupational therapy. It also includes retrospective reviews of inpatient hospital claims to ensure care was medically necessary, required an acute level of care, and was coded and billed correctly. The federal match rate is 75.0 percent.

Long-term care utilization review includes prior authorization reviews to determine medical necessity, level of care, and target population determinations. It also includes periodic reevaluations of services. The federal match for the majority of services is 75.0 percent.

External quality review handles provider credentialing, including activities such as verifying licensure and certification information, validating Healthcare Effectiveness Data and Information Set (HEDIS)

measures, and reviewing provider performance improvement projects. The federal match rate is 75.0 percent.

Mental health external quality review is very similar to the external quality review, but for mental health providers. The federal match rate is 75.0 percent.

Drug utilization review performs prior authorization reviews, retrospective reviews, and provider education to ensure appropriate drug therapy according to explicit predetermined standards.

STATUTORY AUTHORITY: Sections 25.5-5-405, 506, and 411, C.R.S.

REQUEST: The Department requests annualizations of prior year budget actions and adjustments to implement R8, R11, and R10.

RECOMMENDATION: Staff recommends the requested funding. See the discussion of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, UTILIZATION AND QUALITY REVIEW CONTRACTS, PROFESSIONAL SERVICE CONTRACTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION					
SB 17-254 (Long Bill)	$13,824,436	$4,017,493	$470,308	$9,336,635	0.0
Other legislation	$0	$0	$0	$0	0.0
TOTAL	**$13,824,436**	**$4,017,493**	**$470,308**	**$9,336,635**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION					
FY 2017-18 Appropriation	$13,824,436	$4,017,493	$470,308	$9,336,635	0.0
Annualize prior year budget actions	2,263,059	579,577	27,656	1,655,826	0.0
R11 Administrative contracts	1,304,282	1,045,087	831,237	(572,042)	0.0
R8 Medicaid savings initiatives	1,042,615	260,654	0	781,961	0.0
R10 Drug cost containment	282,297	70,574	0	211,723	0.0
TOTAL	**$18,716,689**	**$5,973,385**	**$1,329,201**	**$11,414,103**	**0.0**
INCREASE/(DECREASE)	**$4,892,253**	**$1,955,892**	**$858,893**	**$2,077,468**	**0.0**
Percentage Change	35.4%	48.7%	182.6%	22.3%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$19,684,133**	**$6,215,246**	**$1,329,201**	**$12,139,686**	**0.0**
Request Above/(Below) Recommendation	$967,444	$241,861	$0	$725,583	0.0

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item pays for contract audits of the following:

- Nursing facilities -- These audits determine the costs that are reasonable, necessary, and patient-related, and the results of the audits serve as the basis for rates for the nursing facilities.

- Hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Centers -- These federally-required audits focus on costs and rate data and serve as the basis for reimbursement. Most of the audits are completed from the Medicare cost report and tailored to Medicaid requirements.
- Single Entry Point Agencies -- Cost reports for all 23 Single Entry Point agencies are reviewed, and on-site audits are conducted to the extent possible within the appropriation.
- Payment Error Rate Measurement Project -- Each state must estimate the number of Medicaid payments that should not have been made or that were made in an incorrect amount, including underpayments and overpayments, every three years according to a staggered schedule set up by the federal government.
- Nursing facility appraisals -- Every four years this audit determines the fair rental value (depreciated cost of replacement) for nursing facilities for use in the rate setting process. The next appraisal will occur in FY 2014-15.
- Colorado Indigent Care Program -- These audits are similar to the Medicaid audits of hospitals, FQHCs and RHCs, but for the indigent care program, rather than the Medicaid program.
- Disproportionate Share Hospital Audits -- This federally-required audit looks at qualifying expenditures for Disproportionate Share Hospital (DSH) payments. These payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients.
- Primary Care Program – These audits improve performance and ensure sound fiscal management of the Primary Care Program.

The sources of cash funds are the Hospital Provider Fee, Nursing Facility Fee, CHP+ Trust, and Primary Care Fund. The federal match rate is 50.0 percent.

STATUTORY AUTHORITY: Sections 25.5-6-201 and 202, 25.5-4-401 (1) (a), 25.5-4-402, 25.5-5-408 (1) (d), 25.5-6-106, 25.5-6-107, 25.5-4-105, and 25.5-4-402.3 (3) (a), C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and adjustments for R14 and R18.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION					
SB 17-254 (Long Bill)	$3,254,646	$1,299,343	$312,420	$1,642,883	0.0
Other legislation	$0	$0	$0	$0	0.0
TOTAL	**$3,254,646**	**$1,299,343**	**$312,420**	**$1,642,883**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION					
FY 2017-18 Appropriation	$3,254,646	$1,299,343	$312,420	$1,642,883	0.0
Annualize prior year budget actions	766,466	261,553	0	504,913	0.0
R14 Safety net programs	135,500	28,864	106,636	0	0.0
R18 Cost allocation	25,620	8,394	4,416	12,810	0.0
TOTAL	**$4,182,232**	**$1,598,154**	**$423,472**	**$2,160,606**	**0.0**

EXECUTIVE DIRECTOR'S OFFICE, PROVIDER AUDITS AND SERVICES, PROFESSIONAL AUDIT CONTRACTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
INCREASE/(DECREASE)	**$927,586**	**$298,811**	**$111,052**	**$517,723**	**0.0**
Percentage Change	28.5%	23.0%	35.5%	31.5%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$4,182,232**	**$1,598,154**	**$423,472**	**$2,160,606**	**0.0**
Request Above/(Below) Recommendation	$0	$0	$0	$0	0.0

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The program pursues recoveries from estates and places liens on property held by Medicaid clients in nursing facilities or clients over the age of 55. The contractor works on a contingency fee basis. The remaining recoveries get applied as an offset to the Medical Services Premiums line item.

STATUTORY AUTHORITY: Section 25.5-4-301, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding.

(H) INDIRECT COSTS

STATEWIDE INDIRECT COST ASSESSMENT

This line item finances the Department's indirect cost assessment according to the state plan. The state plan takes costs associated with agencies such as the Governor's Office, the Department of Personnel, and the Department of Treasury that are not directly billed and allocates these costs to each state department. The departments are then responsible for collecting the money from the various sources of revenue that support their activities. Pursuant to JBC policy, the money collected is used to offset the need for General Fund in the executive director's office of each department to ensure that departments have an incentive to make the collections. An increase in the statewide indirect assessment on a department will decrease the need for General Fund in the executive director's office, and vice versa. The indirect cost assessment on a department can change from year to year based on changes in the total statewide indirect cost pool or based on changes in the allocation of costs. The allocation of costs complies with criteria of the Government Accounting Standards Bureau (GASB).

REQUEST: The Department requests an indirect cost adjustment based on OSPB's common policies.

RECOMMENDATION: Staff recommends the request based on the indirect cost plan approved by the JBC.

(2) MEDICAL SERVICES PREMIUMS

This division provides funding for physical health and most long-term services and supports for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term services and supports for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. There is only one line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

MEDICAL SERVICES PREMIUMS, MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$7,597,506,218	$2,091,822,734	$886,211,720	$70,552,476	$4,548,919,288	0.0
HB 18-1161 (Supplemental Bill)	$353,389,551	$53,900,141	($8,927,993)	($246,086)	$308,663,489	0.0
Other legislation	$392,629	$705,532	($46,619)	$0	($266,284)	0.0
Long Bill supplemental add-on	(369,274,338)	(69,870,671)	(10,358,079)	425,041	(289,470,629)	0.0
TOTAL	**$7,582,014,060**	**$2,076,557,736**	**$866,879,029**	**$70,731,431**	**$4,567,845,864**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$7,582,014,060	$2,076,557,736	$866,879,029	$70,731,431	$4,567,845,864	0.0
R9 Provider rates - Across-the-board	30,629,348	9,712,202	1,259,589	0	19,657,557	0.0
R1 Medical Services Premiums	23,709,908	34,215,228	61,220,308	77,582	(71,803,210)	0.0
R16 Emergency transport CPE	18,139,431	(954,707)	9,547,069	0	9,547,069	0.0
R9 Provider rates - Targeted	5,955,571	4,891,706	(274,539)	0	1,338,404	0.0
R7 Community transition services	241,942	120,971	0	0	120,971	0.0
R12 Children's habilitation transfer	67,940	33,971	0	0	33,969	0.0
R6 Home care visit verification	0	0	0	0	0	0.0
Annualize prior year budget actions	(58,943,161)	(15,651,506)	(2,121,707)	(183,864)	(40,986,084)	0.0
R8 Medicaid savings initiatives	(3,659,755)	(2,580,402)	2,732,628	0	(3,811,981)	0.0
R10 Drug cost containment	(1,080,520)	(308,281)	(39,129)	0	(733,110)	0.0
R17 Single assessment tool	(267,050)	(133,525)	0	0	(133,525)	0.0
TOTAL	**$7,596,807,714**	**$2,105,903,393**	**$939,203,248**	**$70,625,149**	**$4,481,075,924**	**0.0**
INCREASE/(DECREASE)	**$14,793,654**	**$29,345,657**	**$72,324,219**	**($106,282)**	**($86,769,940)**	**0.0**
Percentage Change	0.2%	1.4%	8.3%	(0.2%)	(1.9%)	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$7,776,220,407**	**$2,135,888,927**	**$932,965,478**	**$70,288,985**	**$4,637,077,017**	**0.0**
Request Above/(Below) Recommendation	$179,412,693	$29,985,534	($6,237,770)	($336,164)	$156,001,093	0.0

DECISION ITEMS - MEDICAL SERVICES PREMIUMS

➔ R1 MEDICAL SERVICES PREMIUMS

REQUEST

The Department requests a change to the Medical Services Premiums appropriation for both FY 2017-18 and FY 2018-19 based on a new forecast of caseload and expenditures under current law and policy. R1 is presented as a request by the Department, but it is not really discretionary, because it is what the Department expects to spend absent a change to current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriation, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria or plan benefits.

On February 15, 2018, the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2018 forecast is lower than the forecast used for the Governor's request by $369.3 million, including $69.9 million General Fund, in FY 2017-18 and $199.8 million, including $39.9 million General Fund, in FY 2018-19. The cumulative General Fund difference over the two years is $109.8 million lower than the Governor's November request. The table below compares the projected expenditures under the forecast used for the Governor's November request with the updated February 2018 forecast.

Medical Services Premiums November vs February Forecast				
	February Forecast	November Forecast	Dollar Difference	Percent Difference
FY 17-18	$7,582,014,060	$7,951,288,398	($369,274,338)	-4.6%
General Fund	$2,076,557,736	$2,146,428,407	($69,870,671)	-3.3%
Cash Funds	$866,879,029	$877,237,108	($10,358,079)	-1.2%
Reappropriated Funds	$70,731,431	$70,306,390	$425,041	0.6%
Federal Funds	$4,567,845,864	$4,857,316,493	($289,470,629)	-6.0%
Enrollment	1,335,347	1,401,680	(66,333)	-4.7%
FY 18-19	$7,546,780,807	$7,746,557,747	($199,776,940)	-2.6%
General Fund	$2,095,121,458	$2,135,053,824	($39,932,366)	-1.9%
Cash Funds	$925,977,630	$919,747,809	$6,229,821	0.7%
Reappropriated Funds	$70,625,149	$70,288,985	$336,164	0.5%
Federal Funds	$4,455,056,570	$4,621,467,129	($166,410,559)	-3.6%
Enrollment	1,350,445	1,443,895	(93,450)	-6.5%

RECOMMENDATION

Staff recommends using the Department's February 2018 forecast of enrollment and expenditures to modify both the FY 2017-18 and FY 2018-19 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the February forecast is lower than the November forecast by $369.3 million, including $69.9 million

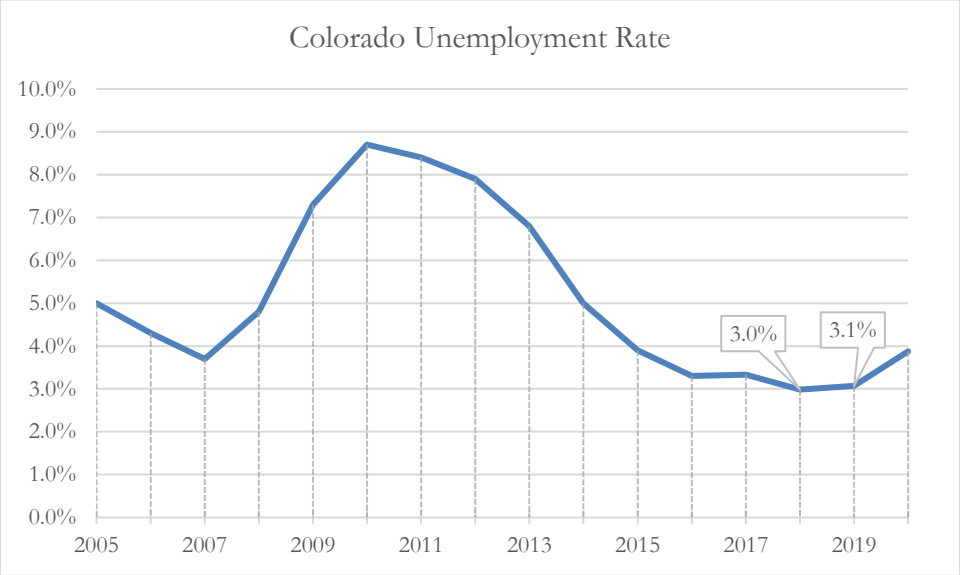
General Fund, in FY 2017-18 and $199.8 million, including $39.9 million General Fund, in FY 2018-19, so the staff recommendation is lower than the Governor's request by these amounts.

FY 2017-18

The next table shows the most significant factors driving the change in the Department's forecast for FY 2017-18. Note that this table displays changes from the appropriation and not changes from FY 2016-17. A negative number does not necessarily indicate negative growth for the fiscal year, but just slower growth than had been assumed for the appropriation.

FY 2017-18 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
FY 2017-18 Appropriation	$7,951,288,398	$2,146,428,407	$947,543,498	$4,857,316,493
Acute Care - Enrollment				
Elderly/People with Disabilities	(1,374,078)	(1,757,139)	1,070,100	(687,039)
Parents/Children/Pregnant - Traditional Match	(75,098,246)	(37,549,123)	0	(37,549,123)
Children/Pregnant Adults - Enhanced Match	(5,065,625)	(607,875)	0	(4,457,750)
ACA expansion	(103,565,904)	0	(5,696,125)	(97,869,779)
Other	1,436,882	550,878	117,294	768,710
Subtotal - Enrollment	*(183,666,971)*	*(39,363,259)*	*(4,508,731)*	*(139,794,981)*
Acute Care - Per Capita				
Elderly/People with Disabilities	(43,207,979)	(17,754,769)	(3,849,220)	(21,603,990)
Parents/Children/Pregnant - Traditional Match	4,723,480	2,820,137	(458,397)	2,361,740
Children/Pregnant Adults - Enhanced Match	(8,971,028)	(1,076,523)	0	(7,894,505)
ACA expansion	(1,955,923)	0	(107,576)	(1,848,347)
Durable Medical Equipment Rates	(14,908,908)	(7,297,495)	(156,958)	(7,454,455)
Other	10,127,807	834,648	291,716	9,001,443
Subtotal - Per Capita	*(54,192,551)*	*(22,474,002)*	*(4,280,435)*	*(27,438,114)*
Long-term Services and Supports				
HCBS waivers	(12,232,410)	(5,561,960)	(554,807)	(6,115,643)
Long-Term Home Health	1,734,064	845,652	6,782	881,630
Private Duty Nursing	(5,284,046)	(2,622,092)	(15,175)	(2,646,779)
Nursing Homes	2,588,844	1,285,605	(37,488)	1,340,727
PACE	293,040	146,520	0	146,520
Hospice	637,460	401,606	(720)	236,574
Subtotal - LTSS	*(12,263,048)*	*(5,504,669)*	*(601,408)*	*(6,156,971)*
Medicare Insurance Premiums	12,135,365	6,552,993	0	5,582,372
Service Management	(17,091,589)	(4,018,706)	(544,441)	(12,528,442)
Other	7,050,204	(174,365)	2,900,665	4,323,904
CHANGE without Billing System Transitions	**($248,028,590)**	**($64,982,008)**	**($7,034,350)**	**($176,012,232)**
Percentage Change	-3.1%	-3.0%	-0.7%	-3.6%
Billing System Transitions				
interChange	(197,370,889)	(25,632,021)	(5,506,839)	(166,232,029)
Pharmacy rebates	76,125,141	20,743,358	2,608,151	52,773,632
Subtotal - Billing system transitions	*(121,245,748)*	*(4,888,663)*	*(2,898,688)*	*(113,458,397)*
CHANGE with Billing System Transitions	**($369,274,338)**	**($69,870,671)**	**($9,933,038)**	**($289,470,629)**
Percentage Change	-4.6%	-3.3%	-1.0%	-6.0%
FY 2017-18 Projection	$7,582,014,060	$2,076,557,736	$937,610,460	$4,567,845,864

- Enrollment -- Enrollment is trending lower than the assumptions used for the FY 2017-18 appropriation, and even below the FY 2016-17 actual enrollment. The Department attributes the trend to economic improvement and the historic low unemployment rate. The overall unemployment rate has been falling in Colorado since 2010, but due to several factors – such as differences in the economic conditions for the lowest wage workers, federal policies that allow workers with improved income to continue receiving Medicaid benefits during a transition period, and the ACA expansion – Medicaid enrollment did not mirror the unemployment trend.



- Per Capita -- One of the larger factors in the lower forecast of per capita expenditures is lower utilization of hepatitis C drugs and lower costs for the drugs than expected. Some of the lower per capita trend might be attributable to the new billing system, which was designed to address and prevent several audit findings of inappropriate payments allowed in the old billing system.
- Durable Medical Equipment – Within the per capita changes, the table specifically highlights a change to durable medical equipment rates. New federal requirements require that aggregate payments not exceed Medicare rates for similar services effective January 2018. Not all durable medical equipment rates are subject to the requirement. Guidance from the federal Centers for Medicare and Medicaid Services (CMS) has changed several times. This estimate was made before the final rates were delivered and takes into account a typical one month delay between utilization and payment.
- Long-term Services and Supports – The projected reduction is the net of several small changes, both positive and negative, in assumptions about the number of utilizers and the units per utilizer.
- Billing System Transitions -- The Department significantly reduced the estimated funds shifted from FY 2016-17 to FY 2017-18 as a result of billing system transitions.
    - InterChange - The Department estimates that a spike in suspended and denied claims due to the interChange billing system, implemented in March 2017, lowered expenditures in FY 2016-17 by $174.2 million total funds, including $30.1 million General Fund. This is significantly lower than the assumption used for the appropriation by $197.4 million total funds, including $25.6 million General Fund. The Department's revised estimate compares payments in the first six months of FY 2016-17 that were for claims incurred in the prior

fiscal year with the same statistic for FY 2017-18. After adjusting for caseload and per capita expenditures, the Department attributes the remaining difference to the new interChange delaying payments.

- Pharmacy rebates -- At the same time the Department replaced the billing system, the Department also replaced a supporting system that helps manage the pharmacy benefit, including prior authorization reviews, preferred drug lists, and drug rebates. After the switch, the Department discovered that the new vendor for the pharmacy benefits management system erroneously billed drug companies for rebates already billed by the previous vendor. The double billing for rebates was due to miscommunication during the transition between vendors for the Pharmacy Benefits Management System, rather than a system error. The Department accounts for drug rebates as an offset to expenditures, and so the excess drug rebates lowered net expenditures in FY 2016-17 and the refund of those rebates will increase net expenditures in FY 2017-18. The final correction for the double billing was $132.1 million total funds, including $36.7 million General Fund. This is significantly higher than the estimate used for the appropriation by $76.1 million total funds, including $20.7 million General Fund, because the double billing occurred for a longer period of time than first assumed.

The Department believes billing conditions are now close to the normal the Department expects and the system is working as intended, with a few isolated exceptions for particular providers. To support this claim the Department notes:

- In December the number of suspended claims dropped below 30,000. The system is designed to suspend claims that require manual intervention to ensure proper payment. For example, when a Medicaid client purchases durable medical equipment, such as a bed, the Department must review the purchase to make sure Medicaid is paying the actual cost and a required prior authorization existed. The Department estimates a workload of 30,000 suspended claims or less can be processed in 10 business days, which is the Department's goal to ensure timely payments. In January, the suspended claims jumped when the federal government released updated billing codes that needed to be entered in the system, but this happens at the start of every calendar year and is not related to the performance of the new billing system.
- Average payments per month are higher than prior to the new MMIS.
- In February, 77 percent of claims submitted paid immediately with no denial or suspension. As noted above, the Department expects a portion of claims to be suspended and the same is true for denials. This level of claims without denial or suspension is in the target range identified by the Department. It suggests that providers are submitting bills and getting paid correctly on the first try for run-of-the-mill claims that do not require any further manual review.
- There was only one request for an interim payment in February. There are 29 active reoccurring interim payments, but these are declining. The Department is trying to let them decrease organically as providers become comfortable with the new billing system, rather than forcing reoccurring payments to end as system fixes are implemented.
- In December the Department implemented a number of fixes, including:
    - Medicaid is now paying coinsurance and deductibles for people dually eligible for Medicaid and Medicare correctly for most providers. The issue is still not fully fixed for payments to the Federally Qualified Health Centers (FQHCs), but the Department and providers have identified a work around until the issue is resolved.
    - Patient liability for nursing homes is now calculating correctly.

  - Batch payments to hospitals are now working as designed (although changes to the payment methodology unrelated to the new system are not necessarily popular).
- The Department recently implemented an enhancement allowing Home- and Community-Based Services providers to see online the prior authorization requirements and associated modifier codes for a client that are necessary to bill properly for services. The Department views the ability of staff to work on system enhancements, rather than fixes, as a milestone.
- The top ten requests in the queue for system changes are for enhancements, rather than system fixes.

FY 2018-19

The next table shows the most significant factors driving the forecasted change in expenditures from FY 2017-18 to FY 2018-19.

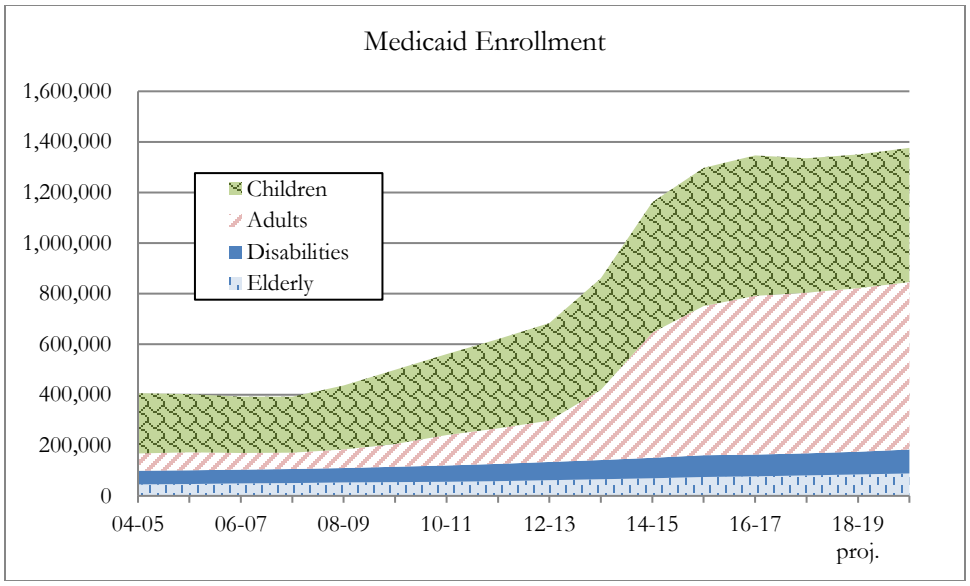
FY 2018-19 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
FY 2017-18 Projection	$7,582,014,060	$2,076,557,736	$937,610,460	$4,567,845,864
Acute Care - Enrollment				
Elderly/People with Disabilities	28,429,991	9,883,098	4,331,897	14,214,996
Parents/Children/Pregnant - Traditional Match	1,317,477	658,738	0	658,739
Children/Pregnant Adults - Enhanced Match	1,124,977	134,997	0	989,980
ACA expansion	21,994,822	0	1,429,663	20,565,159
Other	(58,961)	226,548	(179,220)	(106,289)
Subtotal - Enrollment	*52,808,306*	*10,903,381*	*5,582,340*	*36,322,585*
Acute Care - Per Capita				
Elderly/People with Disabilities	52,857,645	25,523,835	904,987	26,428,823
Parents/Children/Pregnant - Traditional Match	18,304,715	8,564,970	587,387	9,152,358
Children/Pregnant Adults - Enhanced Match	495,019	59,402	0	435,617
ACA expansion	1,642,377	0	106,755	1,535,622
Durable Medical Equipment Rates	(21,141,727)	(10,348,286)	(222,577)	(10,570,864)
Other	1,655,960	4,931,661	(3,363,370)	87,669
Subtotal - Per Capita	*53,813,989*	*28,731,582*	*(1,986,818)*	*27,069,225*
ACC Phase II				
Integration of behavioral/physical health	(57,785,147)	(16,382,919)	(1,766,643)	(39,635,585)
Mandatory enrollment	(41,605,205)	(21,475,675)	(3,383,124)	(16,746,406)
Increase PMPM $1	14,173,668	3,793,503	396,450	9,983,715
Subtotal - ACC - Phase II	*(85,216,684)*	*(34,065,091)*	*(4,753,317)*	*(46,398,276)*
Long-term Services and Supports				
HCBS waivers	49,057,849	24,021,136	302,066	24,734,647
Long-Term Home Health	20,176,876	10,088,438	0	10,088,438
Private Duty Nursing	14,050,405	7,025,202	0	7,025,203
Nursing Homes	31,257,742	15,777,159	13,696	15,466,887
PACE	21,502,173	10,751,087	0	10,751,086
Hospice	3,042,149	1,521,074	0	1,521,075
Subtotal – LTSS	*139,087,194*	*69,184,096*	*315,762*	*69,587,336*
Medicare Insurance Premiums	6,932,805	3,466,402	0	3,466,403
Service Management	1,964,828	982,414	0	982,414
Provider Fees				
Hospitals	97,100,939	0	48,612,590	48,488,349

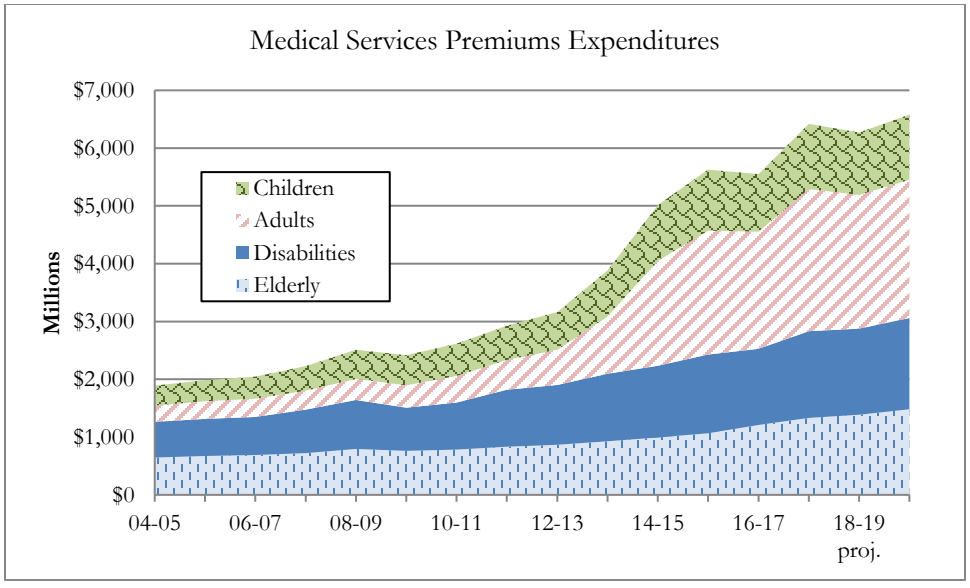
FY 2018-19 Medical Services Premiums Enrollment/Utilization Trends				
	TOTAL FUNDS	GENERAL FUND	Other State	FEDERAL FUNDS
Nursing Homes	3,868,003	0	1,934,001	1,934,002
Subtotal - Provider Fees	*100,968,942*	*0*	*50,546,591*	*50,422,351*
Federal match	0	0	15,614,583	(15,614,583)
Other	668,755	6,137,709	2,152,630	(7,621,584)
CHANGE without Billing System Transitions	**$271,028,135**	**$85,340,493**	**$67,471,771**	**$118,215,871**
Percentage Change	3.6%	4.1%	7.2%	2.6%
Billing System Transitions				
interChange	(174,164,954)	(30,118,262)	(4,549,569)	(139,497,123)
Pharmacy rebates	(132,096,434)	(36,658,509)	(3,929,883)	(91,508,042)
Subtotal - Billing system transitions	*(306,261,388)*	*(66,776,771)*	*(8,479,452)*	*(231,005,165)*
CHANGE with Billing System Transitions	**($35,233,253)**	**$18,563,722**	**$58,992,319**	**($112,789,294)**
Percentage Change	-0.5%	0.9%	6.3%	-2.5%
FY 2018-19 Projection	$7,546,780,807	$2,095,121,458	$996,602,779	$4,455,056,570

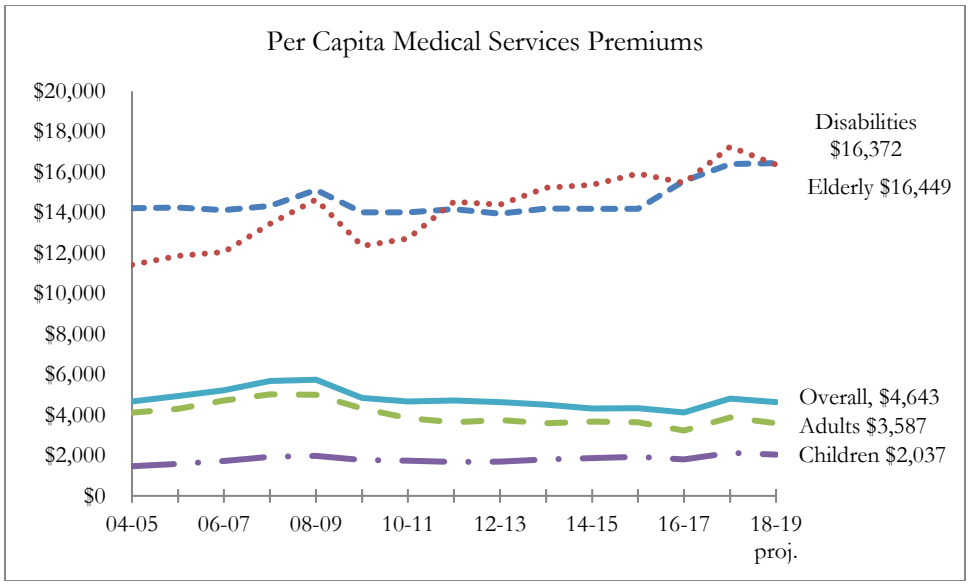
- Enrollment -- For FY 2018-19 the Department projects moderate to very low enrollment growth. The Department does not expect the recent decrease in enrollment to continue. It would be difficult for the unemployment rate to go much lower than the current historic low, but there is some risk it could increase.
- Per Capita -- The projected increase in per capita expenditures is driven by the elderly and people with disabilities and is attributable to an increase in the average age of clients.
- ACC Phase II -- Offsetting the acute care enrollment and per capita trends, the Department assumes significant decreases in per capita expenditures because of the implementation of Phase II of the Accountable Care Collaborative.
- Long-term Services and Supports – The increase is driven by continued growth in the number of utilizers and the units per utilizer across nearly all community-based services. The projection for nursing homes reflects a statutory three percent allowable increase in rates and a small increase in bed days.
- Provider Fees – Supplemental payments to hospitals financed with the HAS Fee and matching federal funds are projected to increase.

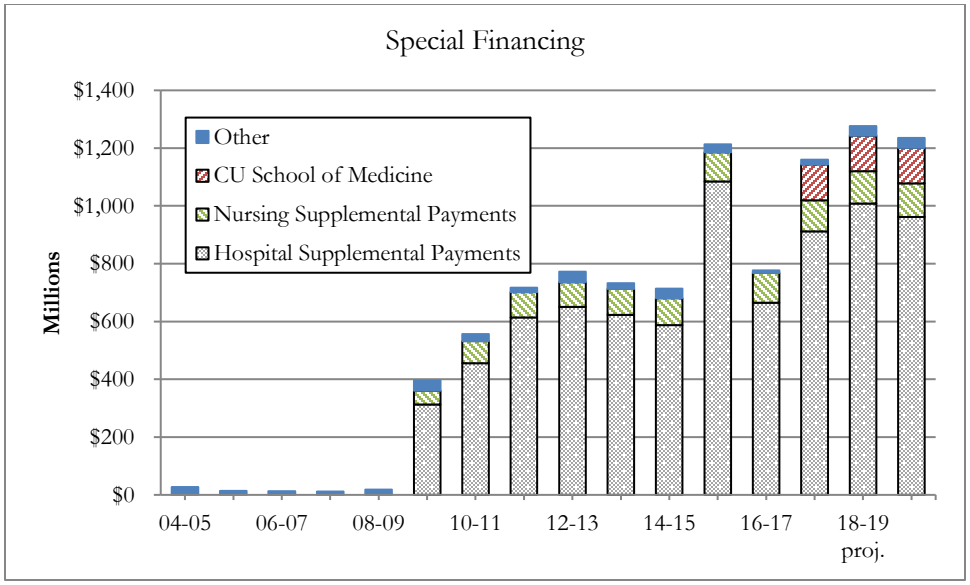
LONG-TERM TRENDS

The next series of graphs summarize longer term trends in Medicaid enrollment and expenditures. In the graphs special financing, such as provider fee payments to hospitals and nursing homes, are shown separately from other costs, because the factors that drive changes in these expenditures are related more to policies of the General Assembly than enrollment and including them with medical services would obscure the trends in medical costs.


Medicaid Enrollment
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
Children
Adults
Disabilities
Elderly
04-05
06-07
08-09
10-11
12-13
14-15
16-17
18-19 proj.


Medical Services Premiums Expenditures
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Millions
Children
Adults
Disabilities
Elderly
04-05
06-07
08-09
10-11
12-13
14-15
16-17
18-19 proj.





LINE ITEM DETAIL

MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS

This line item provides funding for physical health and most long-term care services for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term care services for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. This is the only line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public

hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

STATUTORY AUTHORITY: Section 25.5-5-101 et seq., C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and adjustments for R1, R7, R8, R9, R10, R12, R16, and R17.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

MEDICAL SERVICES PREMIUMS, MEDICAL AND LONG-TERM CARE SERVICES FOR MEDICAID ELIGIBLE INDIVIDUALS						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION						
SB 17-254 (Long Bill)	$7,597,506,218	$2,091,822,734	$886,211,720	$70,552,476	$4,548,919,288	0.0
HB 18-1161 (Supplemental Bill)	$353,389,551	$53,900,141	($8,927,993)	($246,086)	$308,663,489	0.0
Other legislation	$392,629	$705,532	($46,619)	$0	($266,284)	0.0
Long Bill supplemental add-on	(369,274,338)	(69,870,671)	(10,358,079)	425,041	(289,470,629)	0.0
TOTAL	**$7,582,014,060**	**$2,076,557,736**	**$866,879,029**	**$70,731,431**	**$4,567,845,864**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$7,582,014,060	$2,076,557,736	$866,879,029	$70,731,431	$4,567,845,864	0.0
R9 Provider rates - Across-the-board	30,629,348	9,712,202	1,259,589	0	19,657,557	0.0
R1 Medical Services Premiums	23,709,908	34,215,228	61,220,308	77,582	(71,803,210)	0.0
R16 Emergency transport CPE	18,139,431	(954,707)	9,547,069	0	9,547,069	0.0
R9 Provider rates - Targeted	5,955,571	4,891,706	(274,539)	0	1,338,404	0.0
R7 Community transition services	241,942	120,971	0	0	120,971	0.0
R12 Children's habilitation transfer	67,940	33,971	0	0	33,969	0.0
R6 Home care visit verification	0	0	0	0	0	0.0
Annualize prior year budget actions	(58,943,161)	(15,651,506)	(2,121,707)	(183,864)	(40,986,084)	0.0
R8 Medicaid savings initiatives	(3,659,755)	(2,580,402)	2,732,628	0	(3,811,981)	0.0
R10 Drug cost containment	(1,080,520)	(308,281)	(39,129)	0	(733,110)	0.0
R17 Single assessment tool	(267,050)	(133,525)	0	0	(133,525)	0.0
TOTAL	**$7,596,807,714**	**$2,105,903,393**	**$939,203,248**	**$70,625,149**	**$4,481,075,924**	**0.0**
INCREASE/(DECREASE)	**$14,793,654**	**$29,345,657**	**$72,324,219**	**($106,282)**	**($86,769,940)**	**0.0**
Percentage Change	0.2%	1.4%	8.3%	(0.2%)	(1.9%)	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$7,776,220,407**	**$2,135,888,927**	**$932,965,478**	**$70,288,985**	**$4,637,077,017**	**0.0**
Request Above/(Below) Recommendation	$179,412,693	$29,985,534	($6,237,770)	($336,164)	$156,001,093	0.0

(5) INDIGENT CARE PROGRAM

This division contains funding for the following programs: (1) Colorado Indigent Care Program (CICP), which partially reimburses providers for medical services to uninsured individuals with incomes up to 250 percent of the federal poverty level; (2) Children's Basic Health Plan; and (3) the Primary Care Grant Program. The sources of cash funds are the Hospital Provider Fee, tobacco tax money, tobacco settlement money, enrollment fees for the Children's Basic Health Plan, and recoveries and recoupments. The tobacco tax money primarily goes through the Primary Care Fund to provide primary care grants. The tobacco settlement money primarily goes through the Children's Basic Health Plan Trust.

INDIGENT CARE PROGRAM					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 Appropriation					
SB 17-254 (Long Bill)	$543,885,464	$10,409,002	$207,795,688	$325,680,774	0.0
HB 18-1161 (Supplemental Bill)	0	0	0	0	0.0
Other legislation	0	0	0	0	0.0
TOTAL	**$543,885,464**	**$10,409,002**	**$207,795,688**	**$325,680,774**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION					
FY 2017-18 Appropriation	$543,885,464	$10,409,002	$207,795,688	$325,680,774	0.0
R3 Childrens Basic Health Plan	7,490,833	(621,616)	1,034,180	7,078,269	0.0
R14 Safety net programs	586,380	(28,864)	615,244	0	0.0
Other	(19,742)	0	(19,742)	0	0.0
TOTAL	**$551,942,935**	**$9,758,522**	**$209,425,370**	**$332,759,043**	**0.0**
INCREASE/(DECREASE)	**$8,057,471**	**($650,480)**	**$1,629,682**	**$7,078,269**	**0.0**
Percentage Change	1.5%	(6.2%)	0.8%	2.2%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$559,509,035**	**$9,758,522**	**$209,292,844**	**$340,457,669**	**0.0**
Request Above/(Below) Recommendation	$7,566,100	$0	($132,526)	$7,698,626	0.0

DECISION ITEMS - INDIGENT CARE PROGRAM

➔ R3 CHILDREN'S BASIC HEALTH PLAN

REQUEST

The Department requests a change to the appropriation for the Children's Basic Health Plan (CHP+) based on a new forecast of caseload and expenditures under current law and policy. R3 represents the Department's forecast of expenditures based on the eligibility criteria and plan benefits in current law and policy and proposed changes to the eligibility criteria or plan benefits are contained in other requests.

On February 15, 2018, the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. Compared to the Governor's November request, the February 2018 forecast is higher in FY 2017-18 by $4.4 million total funds and lower in FY 2018-19 and $517,837

total funds. The General Fund is unchanged. The table below compares the projected expenditures under the forecast used for the Governor's request with the updated February 2018 forecast.

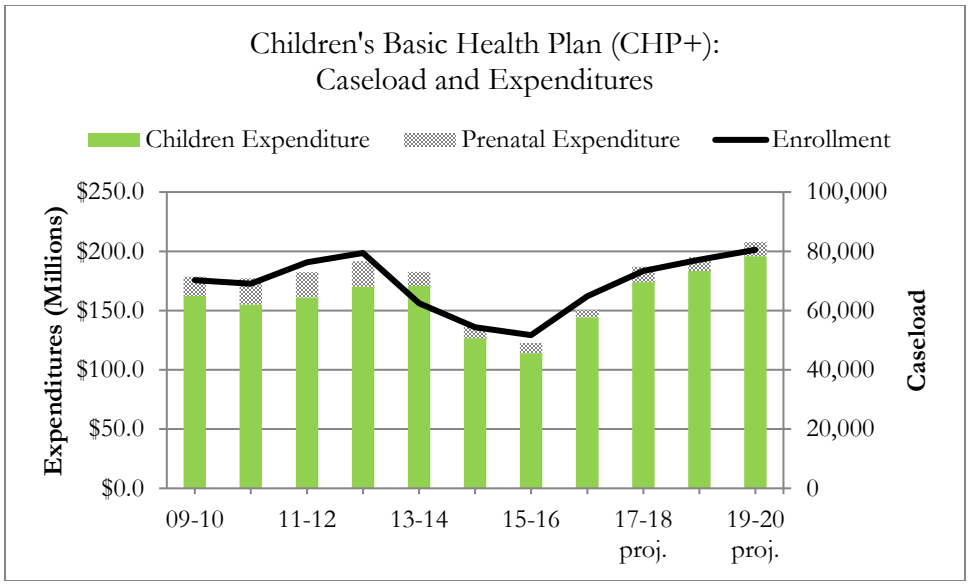
Children's Basic Health Plan				
	November Forecast	February Forecast	Dollar Difference	Percent Difference
FY 17-18	$183,052,432	$187,490,367	$4,437,935	2.4%
General Fund	$621,616	$621,616	$0	0.0%
Cash Funds	$23,303,965	$23,798,089	$494,124	2.1%
Federal Funds	$159,126,851	$163,070,662	$3,943,811	2.5%
Enrollment	74,446	73,372	(1,074)	-1.4%
FY 18-19	$195,499,037	$194,981,200	($517,837)	-0.3%
General Fund	$0	$0	$0	NA
Cash Funds	$24,906,128	$24,832,269	($73,859)	-0.3%
Federal Funds	$170,592,909	$170,148,931	($443,978)	-0.3%
Enrollment	77,977	77,119	(858)	-1.1%

The forecasted General Fund in FY 2017-18 is to reimburse the federal government for disallowed payments in prior years. The majority of the cash funds come from the Children's Basic Health Plan (CHP+) Trust, which receives revenue from the tobacco master settlement, enrollment fees, and interest. The CHP+ program also receives money from the HAS Fee for children and pregnant adults with income from 206 percent to 260 percent of the federal poverty guidelines. Small amounts of the cash funds are from the Colorado Immunization Fund (originally tobacco settlement money), and the Health Care Expansion Fund (originally tobacco tax money). The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. The average federal match rate is 88.0 percent.

Recent federal legislation reauthorized federal funding for CHP+ for five years through federal fiscal year 2022-23. The legislation includes a step down of the federal match rate to 76.5 percent in federal fiscal year 2019-20 and 65 percent in federal fiscal year 2020-21.

RECOMMENDATION

Staff recommends using the Department's February 2018 forecast of enrollment and expenditures to modify both the FY 2017-18 and FY 2018-19 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the February forecast is higher than the November forecast by $4.4 million in FY 2017-18 and lower by $517,837 in FY 2017-18, so the staff recommendation differs from the Governor's request by these amounts. The recommended General Fund is the same as the Governor's request. The graph below illustrates trends in CHP+ enrollment and expenditures.



LINE ITEM DETAIL – INDIGENT CARE PROGRAM

SAFETY NET PROVIDER PAYMENTS

This line item provides funding to partially reimburse hospitals for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to adults and emancipated minors with income to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services beyond emergency care that they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

The source of cash funds is the Hospital Provider Fee and the federal match rate is at the standard Medicaid FMAP. Colorado draws the federal funds for Safety Net Provider Payments through two different methods. First, Colorado's Medicaid rates result in federal reimbursements that are below the federally calculated Upper Payment Limit (UPL), leaving room for Colorado to draw more federal Medicaid funds, if the local match is provided. Second, Colorado receives a federal Disproportionate Share Hospital (DSH) allocation to provide enhanced payments to "safety net" providers who serve a disproportionate share of Medicaid and low-income patients. Federal DSH allotments are required to decrease in aggregate with the implementation of the Affordable Care Act and the expected decrease in the uninsured population.

The Medicaid expansion authorized by S.B. 13-200 significantly reduced the number of people eligible for the CICP, but there is still a population with income above the effective Medicaid eligibility threshold for adults of 138 percent and the CICP eligibility income limit of 250 percent. Also, non-pregnant adult legal immigrants who have been in the United States for less than five years do not qualify for Medicaid, but do qualify for the CICP. Many people eligible for the CICP would also qualify for federal tax credits to purchase insurance through Connect for Health Colorado, but may not be able to meet out-of-pocket expenses.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding based on the expected allocations through the CICP.

CLINIC BASED INDIGENT CARE

This line item is similar in purpose to the Safety Net Provider Payments line item, except that instead of funding hospitals it partially reimburses clinics for uncompensated and undercompensated care provided through the Colorado Indigent Care Program (CICP) to people with income up to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The CICP is NOT an insurance program with defined benefits for the clients. Providers may choose what services they will offer to clients in the CICP. However, in order to receive reimbursement through the CICP the provider must limit CICP client copayments for offered services according to a sliding scale based on income.

Since clinics are not eligible for UPL or DSH financing, the federal funds for this line item are drawn through the UPL for Children's Hospital. The hospital then contracts with the clinics to distribute the money, retaining approximately $60,000 from the total appropriation to cover administrative costs. The clinics are not necessarily affiliated with Children's other than through the contract that allows them to receive the supplemental payments.

The available CICP funding is distributed based on each clinic's share of estimated write-off costs compared to all clinics.

Unlike the Safety Net Provider Payments line item, the state participation for this line item comes from the General Fund. This line item existed prior to H.B. 09-1293, and so using the Hospital Provider Fee to match the federal funds might be viewed as supplanting existing General Fund, which is prohibited in Section 25.5-4-402.3 (5) (a) (I), C.R.S. Also, these are not hospitals, and the hospitals are already giving up a share of their UPL to allow the clinics to receive these supplemental payments. The match rate is at the standard Medicaid FMAP.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests an adjustment to implement R15.

RECOMMENDATION: Staff recommends the requested adjustment to implement R15. Otherwise, staff recommends continuing the historic total distributions to clinics. This program is discretionary, rather than a required component of Medicaid. This program has not traditionally been included in the community provider rate common policy.

PEDIATRIC SPECIALTY HOSPITAL

The line item provides supplemental payments to Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The line item also provides

funding for the Children's Hospital Kids Street and Medical Day Treatment programs, which are not eligible for Medicaid fee-for-service reimbursement, but do qualify for this supplemental payment.

The Kids Street program provides professional and paraprofessional services for up to 10 hours a day at two sites for children six weeks old to six years old who have special medical needs and are commonly dependent on technology for life-sustaining support. The services are provided in lieu of hospitalization or home care and support families seriously stressed by the presence of a child with complex medical needs.

The Medical Day Treatment program serves children and adolescents aged 7 to 21 years of age with chronic illnesses or medical conditions requiring ongoing medical monitoring. Patients are served five days a week at The Children's Hospital's campus in Aurora. Aurora Public Schools provides educational staff and instruction on site. Individual education plans are developed and maintained for the patients. The services reduce hospitalizations and provide psycho-social supports to patients' families.

STATUTORY AUTHORITY: Section 25.5-3-104, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding to continue the historic level of support for the program. This program is discretionary, rather than a required component of Medicaid. This program has not traditionally been included in the community provider rate common policy.

APPROPRIATION FROM TOBACCO TAX FUND TO GENERAL FUND

Section 24-22-117(1)(c)(I)(A), C.R.S. requires that 0.6 percent of all tobacco tax revenues appropriated into the Tobacco Tax Cash Fund be appropriated to the General Fund. Section 24-22-117(1)(c)(I)(B.5), C.R.S. requires that 50 percent of those revenues appropriated to the General Fund be appropriated to the Children's Basic Health Plan. This line item fulfills this statutory requirement.

STATUTORY AUTHORITY: Section 24-22-117(1)(c)(I)(A), C.R.S.; Section 24-22-117(1)(c)(I)(B.5), C.R.S.

REQUEST: The Department requests an adjustment for projected tobacco tax revenues.

RECOMMENDATION: Staff recommends an adjustment based on tobacco tax revenues. The JBC provided authority during the figure setting for tobacco programs to adjust this amount, if necessary, based on the March revenue forecast. The figures in the tables reflect the Governor's request and have not been updated for the most recent forecast.

PRIMARY CARE FUND

Through this line item tobacco tax funds are distributed to providers who:

- Accept all patients regardless of their ability to pay, and use a sliding fee schedule for payments or do not charge uninsured clients for services;
- Serve a designated medically underserved area or population;
- Have a demonstrated track record of providing cost-effective care;
- Provide or arrange for the provision of comprehensive primary care services to persons of all ages;
- Complete an initial screening evaluating eligibility for Medicaid, Child Health Plan Plus, (CHP+) and the Colorado Indigent Care Program (CICP); and
- Operate as a federally qualified health center (FQHC), or a health center where at least 50% of the patients served are uninsured or medically indigent patients, Medicaid, and CHP+.

Awards are based on the percentage of medically indigent clients the provider serves. The Primary Care Fund receives 19 percent of tobacco tax collections annually.

STATUTORY AUTHORITY: Section 25.5-3-301 through 303, C.R.S.

REQUEST: The Department requests an adjustment to implement R14.

RECOMMENDATION: Staff recommends the staff proposed adjustment for R14. In addition, staff recommends an adjustment based on tobacco tax revenues. The JBC provided authority during the figure setting for tobacco programs to adjust this amount, if necessary, based on the March revenue forecast. The figures in the tables reflect the Governor's request and have not been updated for the most recent forecast.

CHILDREN'S BASIC HEALTH PLAN (CHP+) ADMINISTRATION

This line item provides funding for private contracts for administrative services associated with the Children's Basic Health Plan. There is a separate appropriation in the Executive Director's Office for the centralized eligibility vendor for CHP+ expansion populations funded from the Hospital Provider Fee. There are also appropriations in the Executive Director's Office for internal administrative costs, including personal services, operating expenses, and the Medicaid Management Information System.

The sources of cash funds are the Children's Basic Health Plan Trust Fund and the Hospital Provider Fee.

Prior to FY 2016-17 the federal match for this line item was based on a time allocation between Medicaid and CHP+. In order to qualify for CHP+ an applicant must first be determined ineligible for Medicaid. Beginning in FY 2016-17 the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for a new time allocation plan that attributes all of the work of this contractor to the CHP+ match rate.

STATUTORY AUTHORITY: Section 25.5-8-111 and 107, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested continuation funding based on the ongoing contracts for administration of CHP+.

CHILDREN'S BASIC HEALTH PLAN (CHP+) MEDICAL AND DENTAL COSTS

This line item contains the medical costs associated with serving the eligible children and pregnant women on the CHP+ program and the dental costs for the children. Children are served by both managed care organizations and the Department's self-insured network. The pregnant women on the program are served in the self-insured network.

If actual expenditures run higher than the forecast based on the eligibility criteria and plan benefits, the budget is usually adjusted. However, states have more options and flexibility under CHP+ rules to keep costs within the budget than under Medicaid rules. Correspondingly, the statutes provide less overexpenditure authority for CHP+ than for Medicaid. Pursuant to Section 24-75-109(1)(a.5), C.R.S. the Department can make unlimited overexpenditures from cash fund sources, including the CHP+ Trust Fund, but annual overexpenditures from the General Fund are capped at $250,000.

CHP+ caseload is historically highly changeable, in part because there is both an upper limit on income and a lower limit, because to be eligible for CHP+ a person cannot be eligible for Medicaid.
The sources of cash funds include the Children's Basic Health Plan Trust, the Hospital Provider Fee, the Colorado Immunization Fund, the Health Care Expansion Fund, and recoveries and reocupments. The federal match rate is at an enhanced FMAP indexed to the standard state FMAP, except that no federal match is provided for enrollment fees. The projected average federal match rate for state FY 2017-18 is 88.0 percent.

STATUTORY AUTHORITY: Section 25.5-8-107 et seq., C.R.S.

REQUEST: The Department requests *R3 Children's Basic Health Plan* to update the appropriation for a more recent forecast.

RECOMMENDATION: Staff recommends updating the appropriation based on the Department's February 20187 forecast, which is more recent than the November forecast used for the budget request. See the discussion of *R3 Children's Basic Health Plan* for more detail. In addition, the JBC staff recommends permission to adjustment the fund sources to account for the most current projection of tobacco tax revenues, when it becomes available. The staff recommendation for the line item is summarized in the table below.

INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION					
SB 17-254 (Long Bill)	$179,773,700	$621,616	$23,336,070	$155,816,014	0.0
HB 18-1161 (Supplemental Bill)	$0	$0	$0	$0	0.0
Other legislation	$0	$0	$0	$0	0.0
TOTAL	**$179,773,700**	**$621,616**	**$23,336,070**	**$155,816,014**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION					
FY 2017-18 Appropriation	$179,773,700	$621,616	$23,336,070	$155,816,014	0.0
R3 Children's Basic Health Plan	7,490,833	(621,616)	1,034,180	7,078,269	0.0
Other	0	0	0	0	0.0
TOTAL	**$187,264,533**	**$0**	**$24,370,250**	**$162,894,283**	**0.0**

INDIGENT CARE PROGRAM, CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
INCREASE/(DECREASE)	**$7,490,833**	**($621,616)**	**$1,034,180**	**$7,078,269**	**0.0**
Percentage Change	4.2%	(100.0%)	4.4%	4.5%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$195,499,037**	**$0**	**$24,906,128**	**$170,592,909**	**0.0**
Request Above/(Below) Recommendation	$8,234,504	$0	$535,878	$7,698,626	0.0

(6) OTHER MEDICAL SERVICES

This division contains the funding for:

- The state's obligation under the Medicare Modernization Act for prescription drug benefits for people dually eligible for Medicare and Medicaid;
- The Old Age Pension State-Only Medical Program;
- Health training programs, including the Commission on Family Medicine and the University Teaching Hospitals; and
- Public School Health Services.

The sources of cash funds include certified public expenditures by school districts, the Old Age Pension Health and Medical Fund, and the Marijuana Tax Cash Fund. The source of reappropriated funds is transfers within the division from the Public School Health Services line item.

OTHER MEDICAL SERVICES						
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 Appropriation						
SB 17-254 (Long Bill)	$269,910,744	$157,704,437	$57,255,586	$2,566,722	$52,383,999	0.0
HB 18-1161 (Supplemental Bill)	10,469,838	(2,314,420)	6,330,313	0	6,453,945	0.0
TOTAL	**$280,380,582**	**$155,390,017**	**$63,585,899**	**$2,566,722**	**$58,837,944**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION						
FY 2017-18 Appropriation	$280,380,582	$155,390,017	$63,585,899	$2,566,722	$58,837,944	0.0
R4 Medicare Modernization Act	6,915,992	6,915,992	0	0	0	0.0
R14 Safety net programs	27,848	0	27,848	0	0	0.0
BA12 Public school health services	5,045,159	0	2,590,298	0	2,454,861	0.0
NP Family medicine residencies	600,000	300,000	0	0	300,000	0.0
Annualize prior year budget actions	150,000	0	0	75,000	75,000	0.0
TOTAL	**$293,119,581**	**$162,606,009**	**$66,204,045**	**$2,641,722**	**$61,667,805**	**0.0**
INCREASE/(DECREASE)	**$12,738,999**	**$7,215,992**	**$2,618,146**	**$75,000**	**$2,829,861**	**0.0**
Percentage Change	4.5%	4.6%	4.1%	2.9%	4.8%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$293,402,404**	**$162,888,832**	**$66,204,045**	**$2,641,722**	**$61,667,805**	**0.0**
Request Above/(Below) Recommendation	$282,823	$282,823	$0	$0	$0	0.0

DECISION ITEMS – OTHER MEDICAL SERVICES

➔ R4 MEDICARE MODERNIZATION ACT

REQUEST

The Department requests an adjustment to the appropriation to reflect an updated forecast of the state obligation under the Medicare Modernization Act. The Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a

federal formula. This is often referred to colloquially as the "clawback." The size of the state's obligation under the federal formula is influenced by changes in the population that is dually eligible for Medicaid and Medicare, their utilization of prescription drugs, and prescription drug prices.

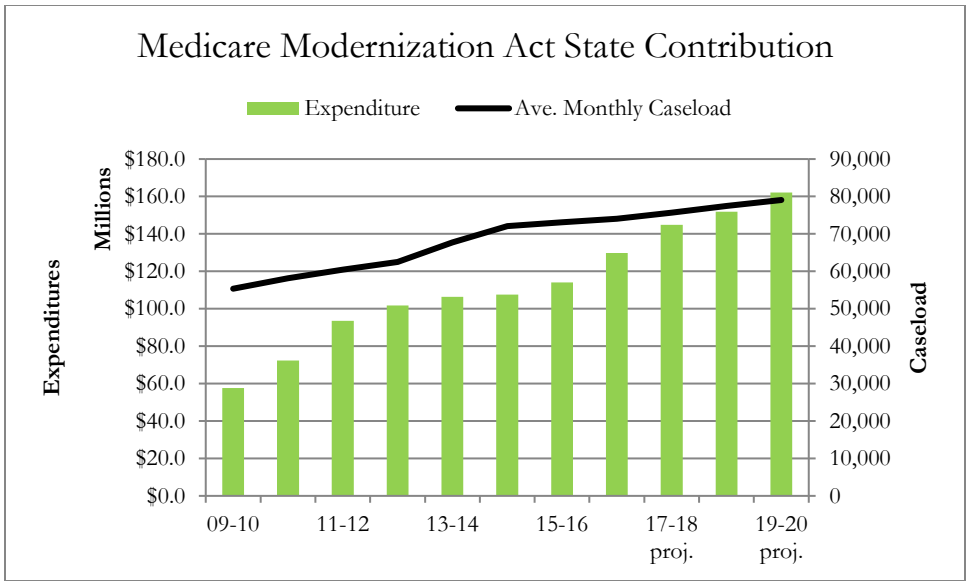
On February 15, 2018, the Department submitted an update to the R4 Medicare Modernization Act forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2018 forecast is lower than the forecast used for the Governor's request by $1.7 million General Fund in FY 2017-18 and $2.0 million General Fund in FY 2018-19.

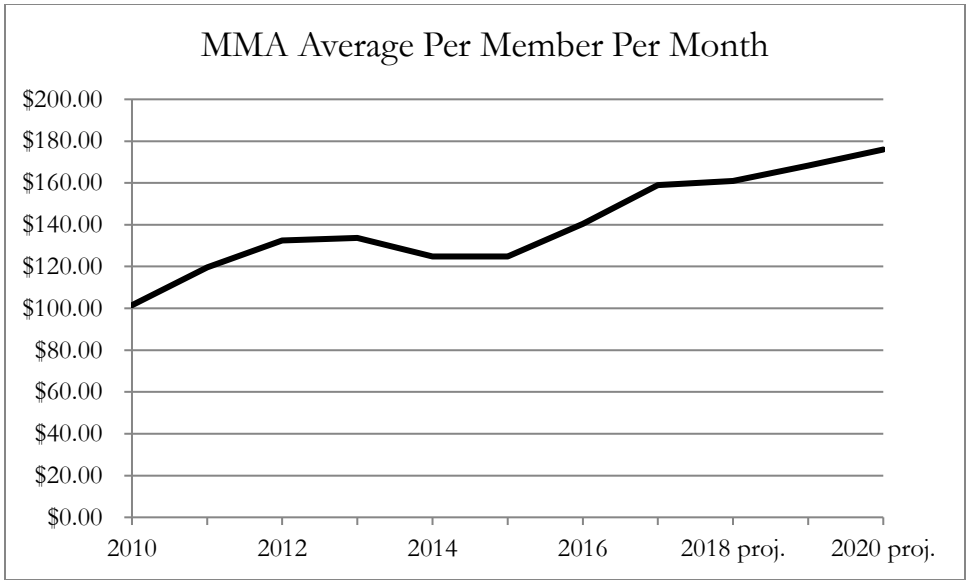
Medicare Modernization Act				
	February Forecast	November Forecast	Dollar Difference	Percent Difference
FY 17-18	$144,919,479	$146,635,899	($1,716,420)	-1.2%
FY 18-19	$151,835,471	$153,834,714	($1,999,243)	-1.3%

RECOMMENDATION

Staff recommends using the Department's February 2017 forecast of enrollment and expenditures to modify both the FY 2017-18 and FY 2018-19 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy. As noted above, the February 2018 forecast is lower than the forecast used for the Governor's request by $1.7 million General Fund in FY 2017-18 and $2.0 million General Fund in FY 2018-19, and so the JBC staff recommendation differs from the Governor's request by these amounts.

Most of the variation in expenditures for this obligation has been due to changes in the per capita drug expenditures estimated by the federal formula, which may not match actual drug expenditures. The growth rate for the population subject to the Medicare Modernization Act has been relatively stable. Changes in the FMAP rate also change the state obligation. The graphs below illustrate trends in the average monthly caseload subject to the Medicare Modernization Act, the total obligation, and the per member per month (PMPM) rate assessed by the federal formula. Note that the PMPM is on a calendar year, while all the other charts show figures by state fiscal year.





This is a 100 percent state obligation with no matching federal funds. However, in some years, in order to offset General Fund costs, Colorado has applied bonus payments received from the federal government for meeting performance goals for enrolling and retaining children in Medicaid and CHP+ toward this obligation. The table below summarizes recent expenditures for the Medicare Modernization Act.

Medicare Modernization Act State Contribution					
Fiscal Year	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	Total Change	Percent Change
FY 08-09	$73,720,837	$73,720,837	$0		
FY 09-10	57,624,126	57,624,126	0	(16,096,711)	-21.8%
FY 10-11	72,377,768	72,377,768	0	14,753,642	25.6%
FY 11-12	93,582,494	93,582,494	0	21,204,726	29.3%

Medicare Modernization Act State Contribution					
Fiscal Year	TOTAL FUNDS	GENERAL FUND	FEDERAL FUNDS	Total Change	Percent Change
FY 12-13	101,817,855	52,136,848	49,681,007	8,235,361	8.8%
FY 13-14	106,376,992	68,306,130	38,070,862	4,559,137	4.5%
FY 14-15	107,620,224	107,190,799	429,425	1,243,232	1.2%
FY 15-16	114,014,334	114,014,334	0	6,394,110	5.9%
FY 16-17	129,807,096	129,807,096	0	15,792,762	13.9%
FY 17-18 proj.	144,919,479	144,919,479	0	15,112,383	11.6%
FY 18-19 proj.	151,835,471	151,835,471	0	6,915,992	4.8%
FY 19-20 proj.	162,042,952	162,042,952	0	10,207,481	6.7%

➔ BA12 PUBLIC SCHOOL HEALTH SERVICES

REQUEST

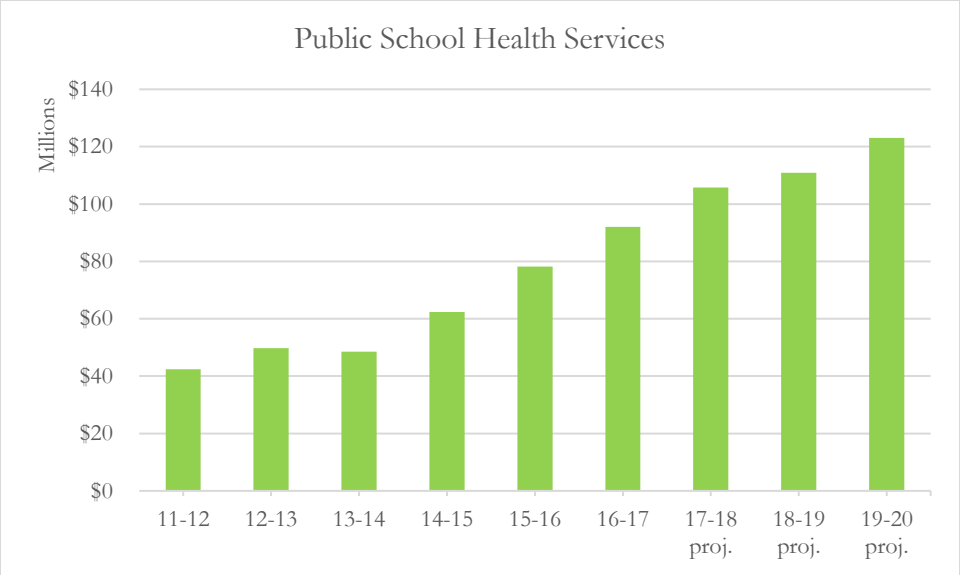
The Department requests three changes to the Public School Health Services line item that the JBC staff has combined into one: an annualization of prior year increase, BA12 to slightly reduce the projected increase, and a non-prioritized budget amendment to correct the requested fund splits. All three are really just a forecast adjustment, and so the JBC staff has combined them to show the net effect, which is an increase of $5.0 million total funds, including $2.6 million certified public expenditures.

Through the Public School Health Services program school districts and Boards of Cooperative Education Services (BOCES) are allowed to identify their expenses in support of Medicaid eligible children with an Individual Education Plan (IEP) or Individualized Family Services Plan (IFSP) and claim federal Medicaid matching funds for these costs. Participating school districts and BOCES report their expenses to the Department according to a federally-approved methodology and the Department submits them as certified public expenditures to claim the federal matching funds. The federal matching funds are then disbursed to the school districts and BOCES and may be used to offset their costs of providing services, or to expand services for low-income, under- or uninsured children and to improve coordination of care between school districts and health providers.

Utilization of the program has increased dramatically in recent years due to a variety of factors, including growth in the number of eligible children in Medicaid, outreach efforts, school districts and BOCES becoming more familiar and comfortable with the required reporting, and the efforts of school districts and BOCES to maximize revenues from all sources to help address tight budgets.

RECOMMENDATION

Staff recommends approval of the request. This request is driven by the amount of expenditures by school districts and BOCES that can be claimed for a federal match. The Department needs the spending authority to distribute the federal funds to the school districts. The certified public expenditures by the school districts and BOCES are not included in the State's calculation of spending that is subject to the limitations in Article X, Section 20 of the Colorado Constitution (TABOR). Approval of this request will not result in any increase in state expenditures.



➔ NP FAMILY MEDICINE RESIDENCIES

REQUEST

The Department requests $600,000, including $300,000 General Fund, for two new family medicine residency programs at Peak Vista in Colorado Springs and Skyridge in Lone Tree. The requested level of funding would allow the Commission to provide these two new residency programs with the same level of support as other programs currently served by the Commission.

RECOMMENDATION

Staff recommends approval of the request. The purpose of the Commission on Family Medicine is to assure standards for training programs, provide financial support, develop and maintain residencies throughout the state and in rural and underserved areas, and provide advice to the General Assembly. The recent creation of two new residency programs outside of the existing network supported by the Commission raises questions about whether the Commission is necessary, or whether residency programs could develop organically on their own the way they do for other specialties. However, for the Commission to perform the functions assigned in statute for these two new programs, it is reasonable for the Commission to have financial resources to provide an equitable level of support. A lack of funding, or a redistribution of existing funding, would compromise the Commission's ability to assure standards for training and coordinate activities between the various family residency programs.

LINE ITEM DETAIL – OTHER MEDICAL SERVICES

OLD AGE PENSION STATE MEDICAL PROGRAM

This line item funds health care services to persons who qualify to receive old age pensions and who are not a patient in an institution for the treatment of tuberculous or mental diseases using a constitutional allocation of sales tax revenues to the Old Age Pension Health and Medical Care Fund. In addition, the line item pays for grants to dental providers to serve low-income seniors who do not otherwise have access to dental care through Medicaid, the Old Age Pension Health and Medical Program, or private insurance. The grants for dental services through the Colorado Dental Program for Low-income Seniors are financed with General Fund ($2,962,510 in FY 2016-17).

With the expansion of Medicaid that was authorized in S.B. 13-200, a large portion of the people eligible for an old age pension are also eligible for Medicaid. All $10.0 million of the constitutional allocation of sales tax is appropriated in this line item to ensure the funds are available to serve eligible people who do not qualify for Medicaid. Any funds left over are reappropriated to the Medical Services Premiums line item to offset the need for General Fund in that line item for people who are dually eligible for Medicaid and the Old Age Pension Health and Medical Program. For FY 2017-18 the Department is projecting $9.0 million will be available to offset General Fund in the Medical Services Premiums line item. If that forecast is off, the Medical Services Premiums line item has statutory authority to overexpend the appropriation.

The Department pays providers for the Old Age Pension Health and Medical Program based on a percentage of Medicaid rates calculated to keep expenditures within the appropriation. With most of the clients now dually eligible for both Medicaid and the Old Age Pension Health and Medical Program, the Department has been able to pay for services at 100 percent of the Medicaid rates.

STATUTORY AUTHORITY: Article XXIV, Section 7, Colorado Constitution; Section 25.5-2-101, C.R.S.; Section 25.5-3-401 et seq., C.R.S.

REQUEST: The Department requests an adjustment in R14 Safety net programs.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

OTHER MEDICAL SERVICES, OLD AGE PENSION STATE MEDICAL				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FTE
FY 2017-18 APPROPRIATION				
SB 17-254 (Long Bill)	$12,962,510	$2,962,510	$10,000,000	0.0
TOTAL	**$12,962,510**	**$2,962,510**	**$10,000,000**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION				
FY 2017-18 Appropriation	$12,962,510	$2,962,510	$10,000,000	0.0
R14 Safety net programs	(2,962,510)	(2,962,510)	0	0.0
TOTAL	**$10,000,000**	**$0**	**$10,000,000**	**0.0**
INCREASE/(DECREASE)	**($2,962,510)**	**($2,962,510)**	**$0**	**0.0**
Percentage Change	(22.9%)	(100.0%)	0.0%	0.0%

OTHER MEDICAL SERVICES, OLD AGE PENSION STATE MEDICAL				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FTE
FY 2018-19 EXECUTIVE REQUEST	**$12,990,358**	**$2,962,510**	**$10,027,848**	**0.0**
Request Above/(Below) Recommendation	$2,990,358	$2,962,510	$27,848	0.0

SENIOR DENTAL PROGRAM

This is a new line item recommended to separate funding for the Senior Dental Program from funding for the Old Age Pension State Medical Program.

Request: The Department did not request this line item.

Recommendation: See the recommendation on R14 for more explanation for the rationale for the new line item.

OTHER MEDICAL SERVICES, SENIOR DENTAL PROGRAM				
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FTE
R14 Safety net programs	$2,990,358	$2,962,510	$27,848	0.0
TOTAL	**$2,990,358**	**$2,962,510**	**$27,848**	**0.0**
INCREASE/(DECREASE)	**$2,990,358**	**$2,962,510**	**$27,848**	**0.0**
Percentage Change	0.0%	0.0%	0.0%	0.0%
Request Above/(Below) Recommendation	($2,990,358)	($2,962,510)	($27,848)	0.0

COMMISSION ON FAMILY MEDICINE

This line item provides payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians (University Hospital's payments are in a separate line item). The funding in this line item goes directly to the residency programs, with the exception of funds to support and develop rural family medicine residency programs pursuant to S.B 14-144. Federal regulations allow Medicaid financial participation for the payments to the hospitals enrolled in the program.

STATUTORY AUTHORITY: Section 25-1-901 et seq., C.R.S.

REQUEST: The Department requests annualizations of prior year budget decisions and the nonprioritized family medicine residencies request.

RECOMMENDATION: The staff recommended changes are summarized in the table below. See the descriptions of the decision items for more detail.

OTHER MEDICAL SERVICES, COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS					
	TOTAL FUNDS	GENERAL FUND	REAPPROPRIATED FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION					
SB 17-254 (Long Bill)	$7,747,298	$3,798,649	$75,000	$3,873,649	0.0
HB 18-1161 (Supplemental Bill)	(150,780)	(390)	(75,000)	(75,390)	0.0
TOTAL	**$7,596,518**	**$3,798,259**	**$0**	**$3,798,259**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION					
FY 2017-18 Appropriation	$7,596,518	$3,798,259	$0	$3,798,259	0.0
NP Family medicine residencies	600,000	300,000	0	300,000	0.0
Annualize prior year budget actions	150,000	0	75,000	75,000	0.0
TOTAL	**$8,346,518**	**$4,098,259**	**$75,000**	**$4,173,259**	**0.0**
INCREASE/(DECREASE)	**$750,000**	**$300,000**	**$75,000**	**$375,000**	**0.0**
Percentage Change	9.9%	7.9%	0.0%	9.9%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$8,497,298**	**$4,098,649**	**$150,000**	**$4,248,649**	**0.0**
Request Above/(Below) Recommendation	$150,780	$390	$75,000	$75,390	0.0

STATE UNIVERSITY TEACHING HOSPITALS – DENVER HEALTH AND HOSPITAL AUTHORITY UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

These two line items provide funding for the Denver Health and Hospital Authority and the University of Colorado Hospital Authority respectively for Graduate Medical Education (GME). Expenses incurred when graduate students see Medicaid patients were previously appropriated in the Medical Service Premiums line item. Separating them in this line item helps to better track these costs and clarify the status of Denver Health and Hospital Authority as a "Unit of Government" with activity the state can certify as public expenditures to match federal funds. The certified public expenditures appear in the Medical Services Premiums line item.

STATUTORY AUTHORITY: Section 25.5-4-106, C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends the requested funding. Traditionally these line items have received periodic rate adjustments rather than the community provider rate common policy adjustment. No rate adjustment was requested for FY 2018-19.

MEDICARE MODERNIZATION ACT

This line item pays the state's obligation under the Medicare Modernization Act (MMA) to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray the costs the federal legislation requires states to make an annual payment based on a percentage of what states would have paid for this population in Medicaid, as estimated by a federal formula.

This is a 100 percent state obligation and there is no federal match. However, in some prior years the General Assembly applied federal bonus payments received for meeting performance goals of the Children's Health Insurance Program Reauthorization Act (CHIPRA) to offset the need for General Fund in this line item.

STATUTORY AUTHORITY: Section 25.5-4-105, C.R.S.

REQUEST: The Department requests R4 Medicare Modernization Act to update the appropriation to match the forecasted state obligation. Although there is no federal match for this line item, the federal match rate for a state affects the federal formula that calculates the state obligation. The effect of the change in the federal match rate is accounted for in the Department's R4.

RECOMMENDATION: Staff recommends adjusting both the FY 2017-18 and FY 2018-19 appropriations based on the updated February 2018 forecast. See the recommendation on R4 Medicare Modernization Act for more detail.

OTHER MEDICAL SERVICES, MEDICARE MODERNIZATION ACT STATE CONTRIBUTION PAYMENT			
	TOTAL FUNDS	GENERAL FUND	FTE
FY 2017-18 APPROPRIATION			
SB 17-254 (Long Bill)	$148,950,319	$148,950,319	0.0
HB 18-1161 (Supplemental Bill)	(2,314,420)	(2,314,420)	0.0
TOTAL	**$146,635,899**	**$146,635,899**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION			
FY 2017-18 Appropriation	$146,635,899	$146,635,899	0.0
R4 Medicare Modernization Act	6,915,992	6,915,992	0.0
TOTAL	**$153,551,891**	**$153,551,891**	**0.0**
INCREASE/(DECREASE)	**$6,915,992**	**$6,915,992**	**0.0**
Percentage Change	4.7%	4.7%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$153,834,714**	**$153,834,714**	**0.0**
Request Above/(Below) Recommendation	$282,823	$282,823	0.0

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION; AND PUBLIC SCHOOL HEALTH SERVICES

When local school districts, Boards of Cooperative Education Services, or the Colorado School for the Deaf and Blind provide health care services to children with disabilities who are eligible for Medicaid, the cost of services covered by Medicaid and some administrative expenses can be certified as public expenditures to match federal funds. The Department allocates the federal financial participation back to the school providers, minus administrative costs, and the school providers use the money to increase access to primary and preventative care programs to low-income, under-, or uninsured children, and to improve the coordination of care between schools and health care providers. Participation by school providers is voluntary.

The source of cash funds is certified public expenditures. The Department retains some of the federal funds for administrative costs up to a maximum of 10 percent pursuant to Section 25.5-5-318 (8) (b), C.R.S. The majority of the federal funds retained by the Department for administrative costs appear in the Contract Administration line item, but there are smaller amounts in the Executive Director's Office and a transfer to the Department of Education as well.

The Contract Administration line item pays for consulting services that help prepare federally required reports, calculate interim payments to the schools, and reconcile payments to actual qualifying expenses. It also pays for travel, training, and outreach to promote the program to school districts and teach them how to submit the claims, especially for medical administration costs at school districts. The Public School Health Services line item represents the payments to the school districts and boards of cooperative education services.

STATUTORY AUTHORITY: Section 25.5-5-318 et seq., C.R.S.

REQUEST: The Department requests BA12 Public school health services to make adjustments based on projected certified public expenditures by schools. The Department also requests an annualization of a prior year forecast adjustment.

RECOMMENDATION: Staff recommends the request, based on the expected certified public expenditures. As noted in the discussion of BA12 above, the JBC staff combined the forecast adjustment in BA12 and the forecast adjustment in the annualization into one issue for purposes of the division summary table.

There have been dramatic increases in recent expenditures, but predicting the increases has proven difficult. The Department attributes the increases to a combination of outreach efforts by the Department, school districts needing to pursue new revenue streams due to the economy, and an increase in Medicaid eligible students. The Department makes an initial payment during the fiscal year, but then makes a reconciliation payment in the next fiscal year. Some of the data points for that reconciliation payment are not available until the spring after the fiscal year when the service was provided, which is after the General Assembly's supplemental process.

OTHER MEDICAL SERVICES, PUBLIC SCHOOL HEALTH SERVICES					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
FY 2017-18 APPROPRIATION					
SB 17-254 (Long Bill)	$93,022,977	$0	$46,505,586	$46,517,391	0.0
HB 18-1161 (Supplemental Bill)	$12,784,258	$0	$6,330,313	$6,453,945	0.0
TOTAL	**$105,807,235**	**$0**	**$52,835,899**	**$52,971,336**	**0.0**
FY 2018-19 RECOMMENDED APPROPRIATION					
FY 2017-18 Appropriation	$105,807,235	$0	$52,835,899	$52,971,336	0.0
BA12 Public school health services	5,045,159	0	2,590,298	2,454,861	0.0
TOTAL	**$110,852,394**	**$0**	**$55,426,197**	**$55,426,197**	**0.0**
INCREASE/(DECREASE)	**$5,045,159**	**$0**	**$2,590,298**	**$2,454,861**	**0.0**
Percentage Change	4.8%	0.0%	4.9%	4.6%	0.0%
FY 2018-19 EXECUTIVE REQUEST	**$110,852,394**	**$0**	**$55,426,197**	**$55,426,197**	**0.0**

OTHER MEDICAL SERVICES, PUBLIC SCHOOL HEALTH SERVICES					
	TOTAL FUNDS	GENERAL FUND	CASH FUNDS	FEDERAL FUNDS	FTE
Request Above/(Below) Recommendation	$0	$0	$0	$0	0.0

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) TRAINING GRANT PROGRAM

This line item pays for grants to organizations to provide evidence-based training for health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse. The source of cash funds is the Marijuana Tax Cash Fund.

STATUTORY AUTHORITY: Sections 25.5-5-208 and 39-28.8-501(2)(b)(IV)(C), C.R.S.

REQUEST: The Department requests continuation funding.

RECOMMENDATION: Staff recommends continuation funding. This is a discretionary expenditure and the JBC could choose to allocate the Marijuana Tax Cash Fund to a different purpose.

LONG BILL FOOTNOTES AND REQUESTS FOR INFORMATION

LONG BILL FOOTNOTES

Staff recommends the following **NEW** footnotes:

N Department of Health Care Policy and Financing, Executive Director's Office, Information technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects; Colorado Benefits Management Systems, Operating and Contract Expenses – These line items include a total of $206,570 ($33,919 General Fund) for administrative costs related to collecting a monthly premium, on a sliding scale based on family income, for the Children's Home and Community Based Services waiver. It is the intent of the General Assembly that the Department of Health Care Policy and Financing submit the planned fees by income tier to the health committees and the Joint Budget Committee in the 2019 legislative session prior to implementing the fees in FY 2019-20.

Comment: See the staff recommendation on R8 related to the parental fee for the rationale.

Staff recommends **CONTINUING AND MODIFYING** the following footnotes:

12 Department of Health Care Policy and Financing, Executive Director's Office, General Professional Services and Special Projects -- This line item includes $62,000 total funds, including $31,000 General Fund, the purpose of which is the autism waiver program evaluation required by Section 25.5-6-806 (2)(c)(I), C.R.S. It is the General Assembly's intent that the Department also use the $62,000 total funds to evaluate the new behavioral therapy benefit through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Comment: This footnote explains the purpose of the appropriation.

14 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses and Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department is authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote. The Department is also authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote to line item appropriations within the Department of Human Services, Office of Information Technology Services, Colorado Benefits Management System subsection.

Comment: This footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System.

18 Department of Health Care Policy and Financing, Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program -- It is the General Assembly's intent that this appropriation be used to sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse that is authorized in Section 25.5-5-208, C.R.S., through:

- Training for health professionals statewide that is evidence-based and that may be either in person or web based;
- Consultation and technical assistance to providers, healthcare organizations, and stakeholders;
- Outreach, communication, and education of providers and patients;
- Coordination with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; and
- Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce the stigma of treatment.

Comment: This footnote explains the purpose of this appropriation from the Marijuana Tax Cash Fund.

Staff recommends **DISCONTINUING** the following footnotes:

11 Department of Health Care Policy and Financing, Executive Director's Office, General Administration, Scholarships for Research Using the All-Payer Claims Database -- The purpose of this appropriation is to provide scholarships for nonprofit and governmental entities to defray the cost of access to the All-Payer Claims Database to conduct research.

Comment: The staff recommendation is to eliminate this line item. If the JBC wants to continue the scholarship program, then the funding should be included in a bill authorizing General Fund for the All-Payer Claims Database.

13a Department of Health Care Policy and Financing, Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals; Office of Community Living, Division of Intellectual and Developmental Disabilities, Program Costs -- The General Assembly assumes federal approval of provider rate increases for Home- and Community-Based Services, except for services funded through the Office of Community Living, will be delayed until October 1, 2017, resulting in a savings of $1,647,446 General Fund. It is the General Assembly's intent that this savings be invested in a rate increase for emergency medical transportation, non-emergency medical transportation, and non-medical transportation of $4,882,669 total funds, of which $1,647,446 comes from the General Fund. The General Assembly assumes that to continue the rate increases for transportation services in FY 2018-19, when the one-time savings from the delay of the Home- and Community-Based Services rate increases is gone, the Department of Health Care Policy and Financing will need $5,855,559 total funds, of which $2,065,366 will come from the General Fund.

Comment: The Department implemented the rate increase as directed.

15 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and

Contract Expenses -- Of this appropriation, $5,345,756 remains available through June 30, 2019.

Comment: This footnote allowed roll forward authority for a limited portion of the appropriations for the Colorado Benefits Management System and was specific to FY 2017-18.

REQUESTS FOR INFORMATION

Staff recommends **CONTINUING AND MODIFYING** the following requests for information:

6 Department of Health Care Policy and Financing, Executive Director's Office -- The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, behavioral health capitation, and the intellectual and developmental disabilities line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month. The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report. The Department is also requested to include in the report the number of applications and the number of approvals for new intermediate care facilities for individuals with intellectual disabilities, including the number of beds and the cost of those beds.

Comment: These reports provide helpful information on expenditure and caseload trends between forecasts, and the JBC is not the only consumer of the reports as research organizations such as the Colorado Health Institute also use the data.

7 Department of Health Health Care Policy and Financing, Indigent Care Program, Safety Net Provider Payments -- The Department is requested to submit a report by February 1 of each year to the Joint Budget Committee estimating the disbursement to each hospital from the Safety Net Provider Payments line item.

Comment: The requested report provides helpful information on the Colorado Indigent Care Program.

8 Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services -- The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: There are frequent questions about the various programs that fund health services in public schools and this report provides useful information to address questions about Medicaid funding and the little understood certified public expenditure financing.

Appendix A: Number Pages

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**						
(1) EXECUTIVE DIRECTOR'S OFFICE						
(A) General Administration						
Personal Services	27,226,976	29,364,616	30,936,372	33,845,196	33,406,387	*
FTE	388.0	418.4	419.2	454.7	448.2	
General Fund	9,828,325	10,232,108	10,518,071	11,220,283	11,132,195	
Cash Funds	2,849,157	2,985,617	2,985,184	3,364,209	3,231,324	
Reappropriated Funds	574,169	1,407,908	1,885,978	2,242,657	2,242,657	
Federal Funds	13,975,325	14,738,983	15,547,139	17,018,047	16,800,211	
Health, Life, and Dental	3,139,489	3,434,070	3,637,126	4,877,767	4,655,810	*
General Fund	1,137,726	1,230,952	1,305,776	1,728,631	1,681,458	
Cash Funds	277,707	337,577	344,132	343,661	297,330	
Reappropriated Funds	88,133	104,755	103,855	135,355	135,355	
Federal Funds	1,635,923	1,760,786	1,883,363	2,670,120	2,541,667	
Short-term Disability	61,246	55,072	58,060	63,422	60,824	*
General Fund	22,736	20,569	21,586	23,533	22,924	
Cash Funds	4,746	4,588	4,802	3,868	3,381	
Reappropriated Funds	1,457	1,393	1,364	1,484	1,484	
Federal Funds	32,307	28,522	30,308	34,537	33,035	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
S.B. 04-257 Amortization Equalization Disbursement	1,314,119	1,434,489	1,615,047	1,926,572	1,858,172	*
General Fund	488,354	535,695	600,398	716,262	700,203	
Cash Funds	101,814	119,586	133,634	116,140	103,331	
Reappropriated Funds	30,035	36,269	37,970	45,371	45,371	
Federal Funds	693,916	742,939	843,045	1,048,799	1,009,267	
S.B. 06-235 Supplemental Amortization Equalization Disbursement	1,269,320	1,419,546	1,615,047	1,926,572	1,858,172	*
General Fund	472,426	530,115	600,398	716,262	700,203	
Cash Funds	98,344	118,340	133,634	116,140	103,331	
Reappropriated Funds	27,570	35,891	37,970	45,371	45,371	
Federal Funds	670,980	735,200	843,045	1,048,799	1,009,267	
Salary Survey	321,383	56,903	614,974	1,203,861	1,203,861	
General Fund	121,695	19,245	228,651	453,147	453,147	
Cash Funds	24,853	6,898	50,834	67,167	67,167	
Reappropriated Funds	1,794	898	14,443	29,534	29,534	
Federal Funds	173,041	29,862	321,046	654,013	654,013	
Merit Pay	317,662	0	291,490	0	0	
General Fund	118,042	0	106,662	0	0	
Cash Funds	26,760	0	25,682	0	0	
Reappropriated Funds	1,975	0	7,235	0	0	
Federal Funds	170,885	0	151,911	0	0	
Worker's Compensation	43,712	54,318	65,937	98,914	98,914	
General Fund	21,856	27,159	32,968	49,456	49,457	
Federal Funds	21,856	27,159	32,969	49,458	49,457	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Operating Expenses	1,930,861	2,024,191	2,190,794	2,235,351	2,210,843	*
General Fund	907,377	947,590	964,715	985,761	980,826	
Cash Funds	3,365	71,522	74,170	103,505	96,873	
Reappropriated Funds	0	10,449	26,219	13,297	13,297	
Federal Funds	1,020,119	994,630	1,125,690	1,132,788	1,119,847	
Legal and Third Party Recovery Legal Services	932,995	941,634	1,114,404	1,302,154	1,302,154	*
General Fund	442,869	338,179	360,583	381,272	381,272	
Cash Funds	23,677	241,591	196,620	269,807	269,807	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	466,449	361,864	557,201	651,075	651,075	
Administrative Law Judge Services	568,419	697,852	647,622	598,050	589,791	
General Fund	220,867	271,159	251,642	232,531	229,321	
Cash Funds	63,343	77,767	72,169	66,494	65,575	
Federal Funds	284,209	348,926	323,811	299,025	294,895	
CORE Operations	1,598,167	1,417,701	1,583,166	1,227,100	1,376,873	
General Fund	544,698	465,080	577,669	447,747	502,399	
Cash Funds	285,501	243,770	257,301	199,432	223,772	
Federal Funds	767,968	708,851	748,196	579,921	650,702	
Payment to Risk Management and Property Funds	166,912	176,936	128,274	92,202	96,768	*
General Fund	83,456	88,468	64,137	46,101	48,384	
Federal Funds	83,456	88,468	64,137	46,101	48,384	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Leased Space	1,848,260	2,026,721	2,514,035	2,514,035	2,514,035	
General Fund	852,378	854,879	1,009,653	1,009,653	1,009,653	
Cash Funds	71,752	247,365	247,365	247,365	247,365	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	924,130	924,477	1,257,017	1,257,017	1,257,017	
Capitol Complex Leased Space	549,237	572,466	666,217	611,650	612,044	
General Fund	274,619	286,233	333,108	305,825	306,022	
Federal Funds	274,618	286,233	333,109	305,825	306,022	
Payments to OIT	3,059,824	4,703,675	5,314,054	5,570,536	5,570,536	*
General Fund	1,518,550	1,974,295	2,226,591	2,354,631	2,354,631	
Cash Funds	11,360	377,545	430,440	430,642	430,642	
Federal Funds	1,529,914	2,351,835	2,657,023	2,785,263	2,785,263	
Scholarships for research using the All-Payer Claims Database	0	499,950	500,000	500,000	0	
General Fund	0	499,950	500,000	500,000	0	
General Professional Services and Special Projects	7,993,989	5,041,327	8,660,571	11,872,661	11,336,417	*
General Fund	2,980,993	1,455,022	2,629,576	4,107,199	3,839,077	
Cash Funds	731,075	936,811	1,600,352	1,728,774	1,728,774	
Reappropriated Funds	0	0	150,000	150,000	150,000	
Federal Funds	4,281,921	2,649,494	4,280,643	5,886,688	5,618,566	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
SUBTOTAL - (A) General Administration	52,342,571	53,921,467	62,153,190	70,466,043	68,751,601
FTE	388.0	418.4	419.2	454.7	448.2
General Fund	20,036,967	19,776,698	22,332,184	25,278,294	24,391,172
Cash Funds	4,573,454	5,768,977	6,556,319	7,057,204	6,868,672
Reappropriated Funds	725,133	1,597,563	2,265,034	2,663,069	2,663,069
Federal Funds	27,007,017	26,778,229	30,999,653	35,467,476	34,828,688
(B) Transfers to Other Departments					
Facility Survey and Certification, Transfer to the Department of Public Health and Environment	5,725,781	6,061,065	7,944,099	7,931,831	7,931,831 *
General Fund	1,918,370	2,060,929	3,025,481	2,976,556	2,976,556
Cash Funds	110,000	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	3,697,411	4,000,136	4,918,618	4,955,275	4,955,275
Nurse Home Visitor Program, Transfer from the Department of Human Services	946,528	195,049	3,010,000	3,010,000	3,010,000
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	428,921	87,892	1,505,000	1,505,000	1,505,000
Federal Funds	517,607	107,157	1,505,000	1,505,000	1,505,000
Prenatal Statistical Information, Transfer to the Department of Public Health and Environment	5,887	5,887	5,887	5,887	5,887
General Fund	2,943	2,943	2,944	2,944	2,944
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,944	2,944	2,943	2,943	2,943

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Nurse Aide Certification, Transfer to the Department of Regulatory Agencies	324,042	324,041	324,041	324,041	324,041	
General Fund	147,369	147,369	147,369	147,369	147,369	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	14,652	14,652	14,652	14,652	14,652	
Federal Funds	162,021	162,020	162,020	162,020	162,020	
Reviews, Transfer to the Department of Regulatory Agencies	5,036	10,000	5,120	5,120	5,120	
General Fund	2,518	5,000	2,560	2,560	2,560	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,518	5,000	2,560	2,560	2,560	
Transfer to the Department of Regulatory Agencie for Regulation of Medicaid Transportation Providers	0	68,257	103,503	103,503	103,503	
General Fund	0	54,507	66,003	66,003	66,003	
Federal Funds	0	13,750	37,500	37,500	37,500	
Public School Health Services Administration, Transfer to the Department of Education	153,845	170,979	181,857	181,857	181,857	*
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	153,845	170,979	181,857	181,857	181,857	
Federal Funds	0	0	0	0	0	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Home Modifications Benefit Administration and Housing Assistance Payments, Transfer to Department of Local Affairs for	0	219,356	219,356	219,356	219,356	
General Fund	0	109,678	109,678	109,678	109,678	
Federal Funds	0	109,678	109,678	109,678	109,678	
Local Public Health Agencies, Transfer to the Department of Public Health and Environment	0	0	720,967	728,177	728,177	*
General Fund	0	0	360,484	364,089	364,089	
Federal Funds	0	0	360,483	364,088	364,088	
SUBTOTAL - (B) Transfers to Other Departments	7,161,119	7,054,634	12,514,830	12,509,772	12,509,772	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,071,200	2,380,426	3,714,519	3,669,199	3,669,199	
Cash Funds	110,000	0	0	0	0	
Reappropriated Funds	597,418	273,523	1,701,509	1,701,509	1,701,509	
Federal Funds	4,382,501	4,400,685	7,098,802	7,139,064	7,139,064	
(C) Information Technology Contracts and Projects						
Medicaid Management Information System Maintenance and Projects	34,365,297	31,555,877	42,221,374	45,246,946	44,894,446	*
General Fund	6,823,650	8,031,732	6,012,929	6,548,026	6,514,276	
Cash Funds	3,099,843	1,800,106	4,288,071	4,452,912	4,445,412	
Reappropriated Funds	293,350	13,366	11,808	6,618	6,618	
Federal Funds	24,148,454	21,710,673	31,908,566	34,239,390	33,928,140	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
MMIS Reprocurement Contracts	41,437,857	16,482,901	18,546,779	5,564	5,564	
General Fund	4,164,679	478,314	1,034,108	0	0	
Cash Funds	1,177,899	507,984	875,342	0	0	
Reappropriated Funds	0	9,675	5,564	5,564	5,564	
Federal Funds	36,095,279	15,486,928	16,631,765	0	0	
Fraud Detection Software Contract	164,143	150,019	115,000	115,000	115,000	
General Fund	62,500	62,500	28,345	28,345	28,345	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	101,643	87,519	86,655	86,655	86,655	
Health Information Exchange Maintenance and Projects	0	6,112,053	8,072,455	7,947,385	7,947,385	
General Fund	0	2,046,246	1,891,246	1,954,794	1,954,794	
Federal Funds	0	4,065,807	6,181,209	5,992,591	5,992,591	
Colorado Benefits Management Systems, Operating and Contract Expenses	0	20,412,988	28,291,745	30,068,611	30,068,612	*
General Fund	0	4,138,421	5,901,509	6,587,252	6,587,252	
Cash Funds	0	2,486,414	3,866,297	3,754,018	3,754,018	
Reappropriated Funds	0	53,221	88,956	94,608	94,608	
Federal Funds	0	13,734,932	18,434,983	19,632,733	19,632,734	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	0	681,776	1,005,415	1,005,415	1,005,415 *
General Fund	0	244,624	312,261	315,815	315,815
Cash Funds	0	95,126	188,319	184,764	184,764
Reappropriated Funds	0	1,711	3,227	3,227	3,227
Federal Funds	0	340,315	501,608	501,609	501,609
Connect for Health Colorado Systems	0	669,328	669,757	669,757	669,757
General Fund	0	0	0	0	0
Cash Funds	0	122,690	122,690	122,690	122,690
Federal Funds	0	546,638	547,067	547,067	547,067
MMIS Reprocurement Contracted Staff	4,448,524	469,690	0	0	0
General Fund	353,814	371,082	0	0	0
Cash Funds	131,360	97,693	0	0	0
Reappropriated Funds	0	915	0	0	0
Federal Funds	3,963,350	0	0	0	0
Centralized Eligibility Vendor Contract Project	2,275,016	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	1,137,508	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,137,508	0	0	0	0

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
SUBTOTAL - (C) Information Technology Contracts and Projects	82,690,837	76,534,632	98,922,525	85,058,678	84,706,179	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	11,404,643	15,372,919	15,180,398	15,434,232	15,400,482	
Cash Funds	5,546,610	5,110,013	9,340,719	8,514,384	8,506,884	
Reappropriated Funds	293,350	78,888	109,555	110,017	110,017	
Federal Funds	65,446,234	55,972,812	74,291,853	61,000,045	60,688,796	
(D) Eligibility Determinations and Client Services						
Medical Identification Cards	182,775	135,912	278,974	278,974	278,974	
General Fund	61,681	44,330	90,988	90,988	90,988	
Cash Funds	30,109	21,664	44,587	44,587	44,587	
Reappropriated Funds	19	14	28	28	28	
Federal Funds	90,966	69,904	143,371	143,371	143,371	
Contracts for Special Eligibility Determinations	8,095,340	7,905,176	11,402,297	11,402,297	11,402,297	
General Fund	904,553	876,881	969,756	969,756	969,756	
Cash Funds	2,763,760	2,659,396	4,343,468	4,343,468	4,343,468	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	4,427,027	4,368,899	6,089,073	6,089,073	6,089,073	
County Administration	43,358,806	45,534,281	68,516,841	61,746,931	68,516,841	*
General Fund	11,114,448	11,114,448	11,114,448	11,114,448	11,114,448	
Cash Funds	5,859,623	5,859,623	14,892,419	10,805,069	14,892,419	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	26,384,735	28,560,210	42,509,974	39,827,414	42,509,974	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
Hospital Provider Fee County Administration	14,485,439	17,184,924	0	0	0 *
General Fund	0	0	0	0	0
Cash Funds	4,945,446	4,945,446	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	9,539,993	12,239,478	0	0	0
Administrative Case Management	869,744	2,155,964	869,744	869,744	869,744
General Fund	434,872	1,077,982	434,872	434,872	434,872
Federal Funds	434,872	1,077,982	434,872	434,872	434,872
Medical Assistance Sites	0	1,435,692	1,531,968	1,531,968	1,531,968
Cash Funds	0	372,429	402,984	402,984	402,984
Federal Funds	0	1,063,263	1,128,984	1,128,984	1,128,984
Customer Outreach	5,309,698	5,379,810	6,607,445	5,948,561	5,948,561
General Fund	2,215,113	2,353,284	2,873,665	2,637,660	2,637,660
Cash Funds	336,620	336,620	336,621	336,621	336,621
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,757,965	2,689,906	3,397,159	2,974,280	2,974,280
Centralized Eligibility Vendor Contract Project	0	3,985,752	5,053,644	5,053,644	5,053,644
Cash Funds	0	1,251,751	1,745,342	1,745,342	1,745,342
Federal Funds	0	2,734,001	3,308,302	3,308,302	3,308,302
Connect for Health Colorado Eligibility Determination	0	4,470,877	4,474,451	4,474,451	4,474,451
General Fund	0	0	0	0	0
Cash Funds	0	1,667,766	1,667,767	1,667,767	1,667,767
Federal Funds	0	2,803,111	2,806,684	2,806,684	2,806,684

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
SUBTOTAL - (D) Eligibility Determinations and Client Services	72,301,802	88,188,388	98,735,364	91,306,570	98,076,480	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	14,730,667	15,466,925	15,483,729	15,247,724	15,247,724	
Cash Funds	13,935,558	17,114,695	23,433,188	19,345,838	23,433,188	
Reappropriated Funds	19	14	28	28	28	
Federal Funds	43,635,558	55,606,754	59,818,419	56,712,980	59,395,540	
(E) Utilization and Quality Review Contracts						
Professional Service Contracts	9,726,242	9,374,992	13,824,436	19,684,133	18,716,689	*
General Fund	2,877,507	3,092,674	4,017,493	6,215,246	5,973,385	
Cash Funds	342,739	311,539	470,308	1,329,201	1,329,201	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	6,505,996	5,970,779	9,336,635	12,139,686	11,414,103	
SUBTOTAL - (E) Utilization and Quality Review Contracts	9,726,242	9,374,992	13,824,436	19,684,133	18,716,689	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	2,877,507	3,092,674	4,017,493	6,215,246	5,973,385	
Cash Funds	342,739	311,539	470,308	1,329,201	1,329,201	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	6,505,996	5,970,779	9,336,635	12,139,686	11,414,103	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
(F) Provider Audits and Services					
Professional Audit Contracts	2,454,646	3,033,408	3,254,646	4,182,232	4,182,232 *
General Fund	1,042,243	1,222,791	1,299,343	1,598,154	1,598,154
Cash Funds	191,893	299,950	312,420	423,472	423,472
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,220,510	1,510,667	1,642,883	2,160,606	2,160,606
SUBTOTAL - (F) Provider Audits and Services	2,454,646	3,033,408	3,254,646	4,182,232	4,182,232
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,042,243	1,222,791	1,299,343	1,598,154	1,598,154
Cash Funds	191,893	299,950	312,420	423,472	423,472
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,220,510	1,510,667	1,642,883	2,160,606	2,160,606
(G) Recoveries and Recoupment Contract Costs					
Estate Recovery	673,182	833,726	700,000	700,000	700,000
General Fund	0	0	0	0	0
Cash Funds	336,591	416,863	350,000	350,000	350,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	336,591	416,863	350,000	350,000	350,000
SUBTOTAL - (G) Recoveries and Recoupment Contract Costs	673,182	833,726	700,000	700,000	700,000
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Cash Funds	336,591	416,863	350,000	350,000	350,000
Reappropriated Funds	0	0	0	0	0
Federal Funds	336,591	416,863	350,000	350,000	350,000

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
(H) All-Payer Claims Database					
All-Payer Claims Database	0	0	0	2,600,000	0 *
General Fund	0	0	0	1,575,000	0
Federal Funds	0	0	0	1,025,000	0
SUBTOTAL - (H) All-Payer Claims Database	0	0	0	2,600,000	0
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	1,575,000	0
Federal Funds	0	0	0	1,025,000	0
(I) Indirect Cost Assessment					
Indirect Cost Assessment	567,546	635,268	911,170	1,138,205	1,138,205
General Fund	0	0	0	0	0
Cash Funds	178,540	224,727	257,456	305,445	305,445
Reappropriated Funds	0	0	117,432	52,041	52,041
Federal Funds	389,006	410,541	536,282	780,719	780,719
SUBTOTAL - (I) Indirect Cost Assessment	567,546	635,268	911,170	1,138,205	1,138,205
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Cash Funds	178,540	224,727	257,456	305,445	305,445
Reappropriated Funds	0	0	117,432	52,041	52,041
Federal Funds	389,006	410,541	536,282	780,719	780,719

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
TOTAL - (1) Executive Director's Office	227,917,945	239,576,515	291,016,161	287,645,633	288,781,158
FTE	388.0	418.4	419.2	454.7	448.2
General Fund	52,163,227	57,312,433	62,027,666	69,017,849	66,280,116
Cash Funds	25,215,385	29,246,764	40,720,410	37,325,544	41,216,862
Reappropriated Funds	1,615,920	1,949,988	4,193,558	4,526,664	4,526,664
Federal Funds	148,923,413	151,067,330	184,074,527	176,775,576	176,757,516

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
(2) MEDICAL SERVICES PREMIUMS					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	6,839,289,152	6,330,278,759	7,582,014,060	7,776,220,407	7,596,807,714 *
General Fund	1,029,604,779	1,032,811,311	1,153,489,403	1,212,820,594	1,182,835,060
General Fund Exempt	809,024,467	830,201,667	923,068,333	923,068,333	923,068,333
Cash Funds	822,942,823	687,831,607	866,879,029	932,965,478	939,203,248
Reappropriated Funds	9,214,192	9,504,132	70,731,431	70,288,985	70,625,149
Federal Funds	4,168,502,891	3,769,930,042	4,567,845,864	4,637,077,017	4,481,075,924
TOTAL - (2) Medical Services Premiums	6,839,289,152	6,330,278,759	7,582,014,060	7,776,220,407	7,596,807,714
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,029,604,779	1,032,811,311	1,153,489,403	1,212,820,594	1,182,835,060
General Fund Exempt	809,024,467	830,201,667	923,068,333	923,068,333	923,068,333
Cash Funds	822,942,823	687,831,607	866,879,029	932,965,478	939,203,248
Reappropriated Funds	9,214,192	9,504,132	70,731,431	70,288,985	70,625,149
Federal Funds	4,168,502,891	3,769,930,042	4,567,845,864	4,637,077,017	4,481,075,924

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
(4) OFFICE OF COMMUNITY LIVING					
(A) Division for Individuals with Intellectual and Developmental Disabilities					
(i) Administrative Costs					
Personal Services	2,673,066	3,262,265	3,427,716	3,523,783	3,523,783
FTE	34.2	40.1	40.1	40.5	40.5
General Fund	1,225,154	1,431,598	1,572,568	1,613,475	1,613,475
Cash Funds	31,234	149,824	297,706	312,854	312,854
Reappropriated Funds	22,109	0	0	0	0
Federal Funds	1,394,569	1,680,843	1,557,442	1,597,454	1,597,454
Operating Expenses	1,301,530	241,483	304,511	290,560	290,560
General Fund	136,796	144,899	120,935	116,311	116,311
Cash Funds	121,027	798	55,677	53,325	53,325
Reappropriated Funds	854,955	0	0	0	0
Federal Funds	188,752	95,786	127,899	120,924	120,924
Community and Contract Management System	61,433	94,096	137,480	137,480	137,480
General Fund	30,717	47,048	89,362	89,362	89,362
Federal Funds	30,716	47,048	48,118	48,118	48,118
Support Level Administration	50,512	52,312	57,418	57,437	57,437
General Fund	25,256	26,156	28,488	28,463	28,463
Cash Funds	0	0	221	255	255
Federal Funds	25,256	26,156	28,709	28,719	28,719

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Cross-system Response for behavioral Health Crises						
Pilot Program	1,695,000	1,690,000	683,750	0	0	
FTE	0.0	0.0	0.0	0.0	0.0	
Cash Funds	1,695,000	1,690,000	683,750	0	0	
Cross-System Response Pilot Program Services	0	1,038,413	1,075,776	837,845	837,845	
Cash Funds	0	730,184	1,075,776	837,845	837,845	
Reappropriated Funds	0	308,229	0	0	0	
SUBTOTAL - (i) Administrative Costs	5,781,541	6,378,569	5,686,651	4,847,105	4,847,105	
FTE	34.2	40.1	40.1	40.5	40.5	
General Fund	1,417,923	1,649,701	1,811,353	1,847,611	1,847,611	
Cash Funds	1,847,261	2,570,806	2,113,130	1,204,279	1,204,279	
Reappropriated Funds	877,064	308,229	0	0	0	
Federal Funds	1,639,293	1,849,833	1,762,168	1,795,215	1,795,215	
(ii) Program Costs						
Adult Comprehensive Services	337,091,139	350,220,297	381,006,241	410,547,779	413,580,567	*
General Fund	169,373,010	176,014,027	185,265,330	205,273,888	206,790,282	
Cash Funds	1	1	5,237,790	1	1	
Federal Funds	167,718,128	174,206,269	190,503,121	205,273,890	206,790,284	
Adult Supported Living Services	62,020,749	72,484,492	74,530,516	85,541,863	83,414,234	*
General Fund	34,961,826	38,522,702	41,146,345	46,542,284	45,457,615	
Cash Funds	0	4,645,469	134,285	270,115	290,969	
Federal Funds	27,058,923	29,316,321	33,249,886	38,729,464	37,665,650	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Children's Extensive Support Services	21,797,924	25,491,608	26,862,221	31,519,597	17,757,697	*
General Fund	11,094,363	12,882,640	13,431,110	15,759,799	8,878,849	
Federal Funds	10,703,561	12,608,968	13,431,111	15,759,798	8,878,848	
Case Management	29,144,892	29,090,388	37,196,712	37,457,163	40,095,913	*
General Fund	15,404,883	15,498,984	19,625,489	19,741,990	21,050,579	
Cash Funds	0	0	30,891	51,478	62,279	
Federal Funds	13,740,009	13,591,404	17,540,332	17,663,695	18,983,055	
Family Support Services	6,960,204	6,960,460	7,058,033	7,108,071	7,108,071	*
General Fund	6,960,204	6,960,460	7,058,033	7,108,071	7,108,071	
Preventive Dental Hygiene	63,334	63,311	64,199	64,654	64,654	*
General Fund	63,334	63,311	64,199	64,654	64,654	
Cash Funds	0	0	0	0	0	
Eligibility Determination and Waiting List Management	2,965,133	3,084,926	3,164,947	3,187,385	3,187,385	*
General Fund	2,948,517	3,067,494	3,144,020	3,166,310	3,166,310	
Federal Funds	16,616	17,432	20,927	21,075	21,075	
Waiver Enrollment	1,586,987	0	0	0	0	
Cash Funds	1,586,987	0	0	0	0	
SUBTOTAL - (ii) Program Costs	461,630,362	487,395,482	529,882,869	575,426,512	565,208,521	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	240,806,137	253,009,618	269,734,526	297,656,996	292,516,360	
Cash Funds	1,586,988	4,645,470	5,402,966	321,594	353,249	
Federal Funds	219,237,237	229,740,394	254,745,377	277,447,922	272,338,912	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
TOTAL - (4) Office of Community Living	467,411,903	493,774,051	535,569,520	580,273,617	570,055,626
FTE	34.2	40.1	40.1	40.5	40.5
General Fund	242,224,060	254,659,319	271,545,879	299,504,607	294,363,971
Cash Funds	3,434,249	7,216,276	7,516,096	1,525,873	1,557,528
Reappropriated Funds	877,064	308,229	0	0	0
Federal Funds	220,876,530	231,590,227	256,507,545	279,243,137	274,134,127

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
(4) INDIGENT CARE PROGRAM						
Safety Net Provider Payments	310,125,957	311,152,663	311,296,186	311,296,186	311,296,186	
General Fund	0	0	0	0	0	
Cash Funds	152,556,889	155,017,426	155,648,093	155,648,093	155,648,093	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	157,569,068	156,135,237	155,648,093	155,648,093	155,648,093	
Clinic Based Indigent Care	6,119,760	6,119,145	6,119,760	6,090,896	6,090,896	*
General Fund	3,011,534	3,047,639	3,059,880	3,031,016	3,031,016	
Federal Funds	3,108,226	3,071,506	3,059,880	3,059,880	3,059,880	
Pediatric Specialty Hospital	13,455,012	13,453,666	13,455,012	13,455,012	13,455,012	
General Fund	6,621,212	6,700,596	6,727,506	6,727,506	6,727,506	
Federal Funds	6,833,800	6,753,070	6,727,506	6,727,506	6,727,506	
Appropriation from Tobacco Tax Fund to the General Fund	427,593	429,444	440,340	420,598	420,598	
Cash Funds	427,593	429,444	440,340	420,598	420,598	
Primary Care Fund	26,778,000	27,276,358	27,767,192	27,714,032	28,382,436	*
Cash Funds	26,778,000	27,276,358	27,767,192	27,714,032	28,382,436	
Children's Basic Health Plan Administration	1,771,063	2,251,214	5,033,274	5,033,274	5,033,274	
General Fund	0	0	0	0	0	
Cash Funds	231,115	270,725	603,993	603,993	603,993	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,539,948	1,980,489	4,429,281	4,429,281	4,429,281	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
Children's Basic Health Plan Medical and Dental Costs	126,415,423	153,062,926	187,490,367	195,499,037	194,981,200 *
General Fund	2,098,125	2,069,366	189,955	0	0
General Fund Exempt	427,593	432,590	431,661	0	0
Cash Funds	26,137,685	22,551,321	23,798,089	24,906,128	24,832,269
Reappropriated Funds	0	0	0	0	0
Federal Funds	97,752,020	128,009,649	163,070,662	170,592,909	170,148,931
TOTAL - (4) Indigent Care Program	485,092,808	513,745,416	551,602,131	559,509,035	559,659,602
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	11,730,871	11,817,601	9,977,341	9,758,522	9,758,522
General Fund Exempt	427,593	432,590	431,661	0	0
Cash Funds	206,131,282	205,545,274	208,257,707	209,292,844	209,887,389
Reappropriated Funds	0	0	0	0	0
Federal Funds	266,803,062	295,949,951	332,935,422	340,457,669	340,013,691

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
(5) OTHER MEDICAL SERVICES						
Old Age Pension State Medical	3,582,551	3,379,476	12,962,510	12,990,358	10,000,000	*
General Fund	2,937,569	2,962,510	2,962,510	2,962,510	0	
Cash Funds	644,982	416,966	10,000,000	10,027,848	10,000,000	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Senior Dental Program	0	0	0	0	2,990,358	*
General Fund	0	0	0	0	2,962,510	
Cash Funds	0	0	0	0	27,848	
Commission on Family Medicine Residency Training Programs	7,597,298	7,597,298	7,596,518	8,497,298	8,346,518	*
General Fund	3,743,374	3,784,182	3,798,259	4,098,649	4,098,259	
Reappropriated Funds	0	0	0	150,000	75,000	
Federal Funds	3,853,924	3,813,116	3,798,259	4,248,649	4,173,259	
State University Teaching Hospitals Denver Health and Hospital Authority	2,804,714	2,804,434	2,804,714	2,804,714	2,804,714	
General Fund	1,380,200	1,396,748	1,402,357	1,402,357	1,402,357	
Federal Funds	1,424,514	1,407,686	1,402,357	1,402,357	1,402,357	
State University Teaching Hospitals University of Colorado Hospital	1,181,204	1,175,387	1,331,984	1,181,204	1,331,984	
General Fund	581,654	585,390	590,992	590,602	590,992	
Reappropriated Funds	0	0	75,000	0	75,000	
Federal Funds	599,550	589,997	665,992	590,602	665,992	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation	
Medicare Modernization Act State Contribution Payment	114,014,334	129,807,096	144,919,479	153,834,714	151,835,471	*
General Fund	114,014,334	129,807,096	144,919,479	153,834,714	151,835,471	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Public School Health Services Contract Administration	923,345	979,431	2,491,722	2,491,722	2,491,722	
General Fund	0	0	0	0	0	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	923,345	979,431	2,491,722	2,491,722	2,491,722	
Federal Funds	0	0	0	0	0	
Public School Health Services	78,309,241	93,151,205	105,807,235	110,852,394	110,852,394	*
General Fund	0	0	0	0	0	
Cash Funds	38,606,226	46,241,334	52,835,899	55,426,197	55,426,197	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	39,703,015	46,909,871	52,971,336	55,426,197	55,426,197	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	0	721,699	750,000	750,000	750,000	
Cash Funds	0	721,699	750,000	750,000	750,000	

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Appropriation	FY 2018-19 Request	FY 2018-19 Recommendation
TOTAL - (5) Other Medical Services	208,412,687	239,616,026	278,664,162	293,402,404	291,403,161
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	122,657,131	138,535,926	153,673,597	162,888,832	160,889,589
Cash Funds	39,251,208	47,379,999	63,585,899	66,204,045	66,204,045
Reappropriated Funds	923,345	979,431	2,566,722	2,641,722	2,641,722
Federal Funds	45,581,003	52,720,670	58,837,944	61,667,805	61,667,805
TOTAL - Department of Health Care Policy and Financing	8,228,124,495	7,816,990,767	9,238,866,034	9,497,051,096	9,306,707,261
FTE	422.2	458.5	459.3	495.2	488.7
General Fund	1,458,380,068	1,495,136,590	1,650,713,886	1,753,990,404	1,714,127,258
General Fund Exempt	809,452,060	830,634,257	923,499,994	923,068,333	923,068,333
Cash Funds	1,096,974,947	977,219,920	1,186,959,141	1,247,313,784	1,258,069,072
Reappropriated Funds	12,630,521	12,741,780	77,491,711	77,457,371	77,793,535
Federal Funds	4,850,686,899	4,501,258,220	5,400,201,302	5,495,221,204	5,333,649,063

APPENDIX B: Scholarships for Research Using the All-Payer Claims Database

APCD Scholarships FY 2016-17			
Organization	Type	Amount	Purpose
Harvard/Columbia	Academic	25,000	This project will explore the experiences of low-income adults gaining coverage in the state of Colorado under the Affordable Care Act. The objective is to identify major differences – if any – between the utilization, health care costs, and quality of care received by low income adults enrolled in public plans (Medicaid) versus those enrolled in private plans (state Marketplace). We believe that knowing the major differences between health care access, costs, and quality for individuals enrolled in private versus public insurance plans will be useful for policymakers both within Colorado and elsewhere in the U.S. in informing discussions about what is and isn't working well in each program. In particular, under the ACA, many states including Colorado have discusssed whether low-income adults would be better served by enrolling in Marketplace plans in lieu of Medicaid (the so-called "private option" being used in Arkansas and Iowa). While this approach may lead to broader access to health providers based on higher reimbursement rates, it is also possible that providers who treat Medicaid patients are particularly well-suited to managing the complex medical and social circumstances of lower-income adults. It is also possible that Medicaid may provide more cost-effective care based on lower payment to providers. All of these are important aspects of health care in Colorado that we seek to explore in order to promote the triple aim of better care, better health, and lower costs.
Liver Health Connections	non-profit	12,956	This project will help Liver Health Connection and the public in several ways: 1. Establish a baseline of cost and prevalence of identified HCV in different payer groups prior to 2014. 2. Tailor advocacy efforts with private insurers and public payers using specific information, particularly with regards to cost. 3. Provide more specific cost information to employers or insurers who are hesitant to provide care. 4. Target specific groups for additional public information, which may be physicians or other health care providers, specific age groups, or geographic areas of the state. 5. Assist work with health care providers to promote prevention within those groups with the highest prevalence of HCV. 6. Provide members of the public with accurate information with regard to risk and cost.
Senator Kefalas	agency	11,200	to obtain a custom report (commercial data) and analysis identifying cost, utilization and claim volume for standalone EDs in Colorado (see the attached application).
UCD Breast Cancer Study	Academic	20,000	The proposed project will use data from the Colorado APCD and link it with data from the Colorado Central Cancer Registry (CCCR) to address the overarching research question: What is the relationship among type of health insurance, socio-economic status and access to a BRCA genetic test for breast cancer patients in Colorado? Additionally, a second, qualitative, phase of the study will include the recruitment of breast cancer patients diagnosed with breast cancer between 2009 and 2014. This project will obtain COMIRB approval to link study participants (who have signed an informed consent form) with the corresponding APCD-CO and CCCR data.

APCD Scholarships FY 2016-17			
Organization	Type	Amount	Purpose
CCHAP	non-profit	3,750	The study will look at the data for two acute care practices utilization of acute care and well child visits and compare data to utilization of EDs and Urgent Cares. The Medicaid population will be given access to a phone app specific to the pediatric population to help families decide whether or not they should go see urgent or emergency services versus scheduling an appointment with the clinic. They will also receive information to phone the medical home and ask questions of a professional to see whether their needs warrant a visit to an urgent or emergent care setting. The utilization of clinic and urgent and emergency room will be compared to see whether having additional resources outside of clinic hours helps to reduce the utilization of urgent and emergency care settings. The anticipation will be that there can be a $250 million savings for Medicaid if applied to whole populations.
UCD Cardiac Test	Academic	25,000	Our objectives are to: 1) validate methods to identify low-value cardiac stress tests (i.e., tests that provide no benefit to patients and can sometimes lead to patient harm), and 2) identify effective ways to reduce low-value stress tests, thereby improving patient outcomes and reducing healthcare expenditures.
Spinal Cord	non-profit	18,072	The overall objective of this project is to understand the prevalence, costs, payer type, and services used by those with spinal cord injuries (SCI). To date, our research has been limited to national estimates and a limited number of sources in Colorado. The CO APCD presents an opportunity to enable our research team to have a deeper understanding of adults with paralysis/physical disabilities resulting from SCI. Project would have a few components: - First part would be to identify all patients with a spinal cord injury in Colorado based on the ICD-9/ICD-10 codes as outlined by Dr. Lanig. Coinciding with this request would be to explore data in the 3M data to see whether they have preventable events and whether that information is valuable to the scope of this project. Patients will be identified by location of service as well as the zip code or HSR where the patient resides. - Second part would be to dig into the detail of the specific event type or trigger to see prevalence of the occurrence and in what setting. - The third would be to see which of the data elements are priority as based on the findings in the first and second part. Dr. Lanig would have the opportunity to see what iteration will be request. - The fourth would be a de-identified data set that could be manipulated by Dr. Lanig's team further to find details in the information related to the purpose of the project. Please note: This application and scholarship request is for the FIRST PART of this project. Additional components will be scoped and applied for separately. This is a more complex request and we are happy to arrange a call with Dr. Lanig and HCPF to discuss questions.
UCD Congenital Heart	Academic	40,000	The Colorado School of Public Health has assembled a team of epidemiologists, health informatics, adolescent and adult congenital heart disease (CHD) cardiologists with active support from lead public health institutions in Colorado including the Colorado Department of Public Health and Environment to develop a state-wide population-based surveillance system of congenital heart defects among individuals aged 11 to 64 years in Colorado. Our project is funded by the Centers for Disease Control and Prevention (CDC) and Colorado was selected as one of five sites across the U.S. to develop a surveillance system for CHDs across the lifespan. The outcomes of this project will be achieved through the development of a congenital heart disease (CHD) surveillance database that will be used for research purposes to quantify the burden of CHD among adolescents and adults in Colorado.

APCD Scholarships FY 2016-17			
Organization	Type	Amount	Purpose
HPV UCD Vaccinations	Academic	33,232	The overall objective of this study is to identify provider barriers to attaining adequate immunization of adolescents with HPV vaccine, and understand provider barriers, attitudes and practices towards HPV vaccination.
HCPF Access to Care Refresh	agency	20,000	Per SB15-228 and the access to care federal rule, the Department is to provide analyses comparing Medicaid reimbursement rates to reimbursement rates from Medicare, commercial carriers, and in some instances other State Medicaid programs. More specifically, for identified services which lack a valid Medicare comparison, the Department shall find and identify a data source that will estimate the usual and customary rate paid in a commercial health plan; HCPF would like to utilize APCD data to determine the usual and customary commercial rates for a select set of services.
UCD Predictors of High Cost	Academic	33,232	We propose an observational study to compare and contrast prescribing and treatment patterns at different cancer stages by provider type, insurance reimbursement model, and by distance to specialized care. A key aspect of our proposal is the linkage of the All Payers Claim Dataset (APCD) to Colorado Central Cancer Registry (CCR) to allow us to determine cancer stage, provider type, and geographic location of both patients and treating physicians. We are requesting CIVHC to perform the linkage as it will require access to several Protected Health Information (PHI) fields. The research team can provide technical assistance to CIVCH to perform the linkage (please see section "A. Linkages to Other Datasets" below). Our specific aims are: Aim 1: To describe the use of newer systemic agents in common and rare cancers and by cancer stage. Aim 2: To compare the use of new systemic agents in rural and urban treatment centers. Aim 3. To estimate total utilization and cost of medical treatment for patients receiving newer systemic agents compared to standard therapy.
CIVHC Care Transitions	non-profit	13,400	To track data relevant to care transitions, including all-cause readmission for state overall, by LOB, and by county.
UCD social Newtwork for CHD	Academic	26,288	The purpose of this study is to identify some of the mechanisms by which the transition to adult care settings occurs. In Colorado access to and supply of healthcare providers have been acknowledged as a challenge and thus identifying ways by which we can leverage provider relationships to improve care transitions is important. It is expected that one of the ways in which ACOs function to create better outcomes is to allow for more effective care coordination, particularly on a system or organizational level. Social network analysis (SNA) provide researchers with a way to measure care coordination that does not require surveys or access to patient medical records. By creating physician patient-sharing networks from the claims data, network measures of care coordination can be obtained to measure care coordination and informational relationships. Studies suggest that physicians sharing 8 or more patients have not only a referral relationship but an informational relationship as well.13 These sorts of provider relationships increase the likelihood of ACHD patients successfully transitioning to adult care settings.

APCD Scholarships FY 2016-17			
Organization	Type	Amount	Purpose
Spinal Cord Injury	non-profit	16,056	This project has four components: 1.To more accurately identify all patients with a spinal cord injury in Colorado based on the ICD-9/ICD-10 codes as outlined by Dr. Lanig. Coinciding with this request would be to explore claims data in a 3M-like approach to identify potentially preventable events and to determine whether that furthers informs the intended scope of this project. Patients will be identified by location of service as well as the zip code or HSR where the patient resides. 2.To dig into the detail of specific event types to see prevalence of the occurrence and in which care settings. 3.Toidentify which data elements are priority , based on the findings in the first and second part. Dr. Lanig would have the opportunity to see what iteration will be requested. 4.To review de-identified data that could be manipulated further to find details in the information related to the purpose of the project.
U Mass Effect of Utilization	Academic	16,880	In this project, I will examine the relationship between referral patterns and utilization patterns and cost, access, quality, and utilization outcomes. I will use enrollment and claims data to examine different measures of referral patterns and utilization patterns, including standard coordination (referral) measures from the health services literature, social network analysis, referral concentration, time to treatment, distance to treatment, and other characteristics of treatment patterns. I will examine variation by plan type and insurer in provider networks, prices, and utilization, as well as their association with referrals and utilization patterns. I will examine influences on these referral/utilization pattern measures as well as the influence of referral/utilization pattern measures on cost, access, quality, and utilization outcomes. Quality measures used will be process measures calculated from the claims data and/or merged on from other datasets at the provider/hospital level (as described below).
UCSF	Academic	32,000	: Long term goal is to understand what clinical resources adults with chronic complex childhood conditions need and what policies help them obtain those resources. The central hypothesis was formulated based on prior reports suggesting significant gaps in performance combined with evidence of frequent complications and high cost. The rationale for the proposed project is that understanding the associations of clinician practice patterns and policies with outcomes will help society improve practice and choose optimal policies. Aim 1: To describe provider-level and regional variation in utilization, costs and quality. Aim 2: To assess the association of quality performance with clinical outcomes Aim 3: To determine whether the insurance status of adult CCCC patients changed with the ACA implementation. Aim 4: To evaluate whether ACA changed quality performance and outcomes and quality measures for adult CCCC patients.

APCD Scholarships FY 2016-17			
Organization	Type	Amount	Purpose
Cost Commission	agency	33,376	The original DoI request was to compare price variation for hip replacement, knee replacement, colonoscopy, and CT, MRI and other imaging procedures across different regions of the state. The Commission was interested in differences observed across geographic rating areas and the major cities of Colorado: Denver, CO Springs, Pueblo, Ft. Collins/Greeley, Grand Junction, and Durango. The Cost Commission now requests additional analysis updated with more recent information. The goal is to develop a better understanding of variation in service utilization (potentially unnecessary) and its impact on the cost of health care across regions of Colorado.
CIVHC Medicare FFS Transfer	non-profit	18,400	Improving the value of Colorado health care through all payer claims Database analysis and reporting
Duke Refresh	Academic	10,000	This project investigates the effect of Colorado's health exchange on healthcare utilization, and how the variation in exchange premiums across the state is affected by the interaction of market structure, selection, and location. Individuals purchasing coverage through the individual exchange might have been previously uninsured, covered by an employer-sponsored plan, or covered by an off-exchange, non-group plan. This project will first answer whether the high degree of cost-sharing of the exchange plans affects the behavior of individuals enrolled in an on-exchange plan, and whether there is any adverse or advantageous selection onto the exchange. Secondly, the project investigates how the selection of individuals onto the exchange will affect the insurer's entry and pricing decisions, as well as the prices they are able to negotiate with providers by modeling the bargaining between providers and insurers. Please note that this is a re-fresh of the data set they have already received. They are going to look at all of 2016 data and compare to results from prior data they had before. I'm including the presentation that they gave here which was well received and insightful.
Boston College Behavioral Health	Academic	15,424	The goal of this research project is to study the effects of practical policies designed based on insights from Behavioral Economics that have the potential to increase the welfare of Colorado residents and maintain the stability of the non-group health insurance market in the long run. Goal: Motivated by these behavioral theories, the aim of this research project is to simulate the effects of potential practical behavioral policies including smart default policies and other nudges, and to study how simple changes in the default options would improve and simplify the enrollment process on the ACA Exchange by reducing the cognitive effort costs of the decision making problem. The new theoretical model developed in this project shows that these nudging policies would lead to higher enrollment rates, encourage more active consumer choices and reduce the average cost of the risk pool on the non-group market. This would help mitigate the problem of adverse selection and allow insurance companies to charge lower premiums and offer more generous benefits to Colorado residents. Furthermore, the smart default policies studied by this project can also be used as a potential (softer) substitute or complement of the individual mandate regulation in order to stimulate higher enrollment rates on the Exchange. Therefore, the results of this project would provide important new insights for healthcare policy design.

APCD Scholarships FY 2016-17			
Organization	Type	Amount	Purpose
YI Invincilbes	non-profit	10,000	The goal of the project is to test whether targeted digital advertising encouraging young adults to access preventive care in rural areas of the state has the potential to increase use of preventive care by young Coloradans ages 18 to 34. This is a two part request. Scholarship is only being requested for the first part which is to look at the historical data associated with preventative service use in this population. Once the targeted marketing is completed the second part of the request will be completed to show the impact of that marketing.
UCD and Northwestern	Academic	38,944	The overall objective of this study is to assess the health effects associated with unconventional natural gas development (UNGD). This overall goal will be realized through two specific aims, each employing the use spatio-temporal models. Our first specific aim focuses on the association between UNGD and exacerbations related to health conditions which have short latencies between the exposure and the health effect. These include certain respiratory, neurological, cardiovascular, and urological conditions. Our second specific aim seeks to understand the association between UNGD and the onset of conditions with longer latency periods between exposure and the health effect. These conditions include certain types of cancers and birth outcomes.
Cost of Care End of Life	non-profit	26,740	The goal of this project is to describe the costs associated with dying in Colorado. This project will contribute to the continued national conversation about medical expenditures at the end of life. Nationally we know that about 25% of Medicare FFS dollars go to care in the last year of life. We don't know whether this is also true in Colorado, and whether there are differences among different payers. This project will provide unique insight into how costs are distributed in the last year of life and what sort of services are utilized. We will use death registry data to identify Colorado adults who died of non-traumatic causes. We will match this list to Colorado APCD claims data to identify all costs that occurred in the year prior to death to determine costs and healthcare utilization.
TOTAL		**$499,950**	

APCD Scholarships FY 2017-18			
Organization	Type	Amount	Purpose
SLV PHP	non-profit	12,000	To obtain the CIVHC Outpatient Outmigration Report Provider/Service Category report. SLVPHP would like to examine data for care provided outside the San Luis Valley (HSR 8) to track gaps in services, costs to the local community to travel, health status, and health-sector workforce shortages. This information will help inform efforts to address workforce shortages and identify areas of need and trends in healthcare, medical transportation, and care coordination.
CHI Hep C Project	non-profit	24,552	The project is in coordination with CDPHE on a recently released Statement of Work. The overarching goal of the project is to improve the understanding of the epidemiology of viral hepatitis in CO. The project serves to build capacity to enhance viral hepatitis programs by developing and utilizing epidemiologic profiles to document, interpret, and frame the dimensions and burden of the epidemic in local terms. The project is intended to enhance laboratory reporting of serologic results and surveillance follow-up with physician offices. Electronic laboratory reports will be imported into a web-based, de-duplicated, population-based surveillance database for infectious disease including all cases of hepatitis C infection. The project will address those disproportionately impoverished populations and people who inject drugs as at risk for both the hepatitis C virus.
NWCCHP	non-profit	29,288	This project will enhance the Northwest Colorado Community Health Partnership by facilitating the development of a regional network of care for Northwest Colorado to include oral health, behavioral health, health promotion, disease prevention, chronic disease management and acute care for the entire regional population. In addition, CIVHC data will be used as a foundation to transformation and mapping utilization in a 5 county region and will help lead to transparency and agreements within our healthcare community. CIVHC data will help multi-sector coordination and improve achieving IHI Triple AIM outcomes which is made possible through measuring data provided by CIVHC. The objective of the project is to bring data to providers in the regional network to assess health care utilization patterns and cost, identify opportunities for care quality improvement, and assess the impact of care management for their patients. NCCHP will provide CIVHC with a list of patients who are Community Care Team managed members from the RMHP Essette Care Management tool. This list will be used to identify patients included in this data set.
NWCCHP	non-profit	16,160	: Describe health conditions, health care utilization and cost indicators for the population served by the Northwest Colorado Community Health Partnership, in the region as a whole, by county groups, county and by zip code when data allows (see list of counties below). Additionally, this project will compare health care utilization and cost indicators between population overall and population receiving care management, and population with mental health conditions vs. population with mental health conditions receiving care management. NCCHP will provide CIVHC with a list of patients who are Community Care Team managed members from the RMHP Essette Care Management tool.

APCD Scholarships FY 2017-18			
Organization	Type	Amount	Purpose
BVIPA	non-profit	30,000	To achieve the BVIPA goals, we have worked on improving physician communication and integration via our internal policies. We now want to improve the value of care we provide to the citizens of Boulder County via the use and analysis of data regarding chronic care issues. The data analysis would then be used to reach out to individual physicians regarding their performance. Data will be provided for all of BVIPA PCP's and specialists in terms of overall costs PMPM per PCP, costs per specific disease states per PCP's, how many patients they are treating for these specified disease states, and costs for specific procedures for some specialists. In the studies outlined in the application, BVIPA will match numbers of patients per each relevant provider for the disease studied with numbers of office visits, appropriate meds, and appropriate lab tests in order to assess physician quality and efficiency. BVIPA will be able to identify gaps in care and pursue improvement opportunities and track outcomes of selected interventions using the PCP data. Total cost of care reports might be another area of actionable data. BVIPA also is asking for market data that would include CPT cost analysis for payers and providers. This will help in keeping costs low while improving quality. As with most IPA's, funds are limited. BVIPA's operating income derives from dues payments from their members. BVIPA can therefore afford to license only very limited data from APCD without a scholarship. With limited data it will be difficult for BVIPA to meet their goal of supporting the Triple Aim.
LARC	state agency	13,592	This project seeks to support a strategic and targeted outreach effort to increase access and use of Long Acting Reversible Contraceptives (LARCs) among women using contraceptives in Colorado. Specifically, this analysis could identify categories of patients with whom there is the lowest adoption of LARCs (by age range, county/zip, etc.) or by identifying types of providers, provider settings or health systems within which there are lower rates of adoption of LARC than the rest of the state. At a high-level, this analysis compares the population who use LARCs with the population who do not. The state has made huge strides in the last couple of years so the older available public health data will not provide the detailed and up-to-date level of insight needed to develop a strategic and cost-effective outreach strategy.

APCD Scholarships FY 2017-18			
Organization	Type	Amount	Purpose
CCMCN	non-profit	44,536	The overall objective of this project is to integrate data from the CO All Payer Claims Database to Community Health Centers Electronic Health Records data. The integrated dataset will allow the Colorado Community Managed Care Network (CCMCN) to produce utilization, cost and quality indicator reports to support safety net population health improvements with its Community Health Centers (CHC) members. With data received from the CO-APCD, CCMCN will provide utilization, cost and quality reports to CHCs that will help them inform and improve their performance for several programs: I. Accountable Care Collaborative - Key Performance Indicators II. Health First Colorado – Children and Adolescents, Family Formation, Adults and Dual Populations III. Accountable Care Collaborative Phase II IV. Federally Qualified Health Centers Uniform Data System Annual Report V. Utilization to inform care management VI. Cost analysis to inform Alternative Payment Models initiatives VII. Medicare Shared Savings Program VIII. Colorado Indigent Care Program (CICP) Incentives As a note, we did discuss work with RCCOs. They are collaborating with them and will work with them once they receive the data to create improvement initiatives. Data they receive from the RCCOs do fall outside of their EHR and so receiving the data from the CO APCD and pairing it with their EHR is paramount to having successful outcomes.
NH Ins. Dept	state agency	13,888	The New Hampshire Insurance Department is required by statute to complete an annual report and hold an annual hearing on medical cost drivers and their impact on premiums in the state. Previous reports can be found on our website but do not include the required comparison and analysis of NH claims data to insurance claim data collected by other states. We hope to use CO and other states' data to accomplish that requirement.
Doctors Care Premium	non-profit	9,400	: Doctors Care is piloting a Premium Sponsorship Program to assist eligible individuals and families with purchasing a Silver Plan on the Connect for Health Colorado health insurance exchange. The objective of our evaluation project is to assess the cost impact of providing premium sponsorship to individuals who would otherwise not be able to afford insurance or who would have chosen a Bronze plan based on the cost of the premium. There are two pulls with this request. We will be asking for the full scholarship amount. The second pull will occur in FY 2018. Invoices will be sent as the data sets are delivered.
Doctors Care Premium	non-profit	23,912	Doctors Care is piloting a Premium Sponsorship Program to assist eligible individuals and families with purchasing a Silver Plan on the Connect for Health Colorado health insurance exchange. The objective of our evaluation project is to assess the cost impact of providing premium sponsorship to individuals who would otherwise not be able to afford insurance or who would have chosen a Bronze plan based on the cost of the premium. There are two pulls with this request. We will be asking for the full scholarship amount. The second pull will occur in FY 2018. Invoices will be sent as the data sets are delivered.

APCD Scholarships FY 2017-18			
Organization	Type	Amount	Purpose
Summit County	non-profit	In Process	Summit County continues to be part of the region in Colorado that has some of the highest cost health insurance premiums in the country. Despite various local and state targeted efforts to reduce the premiums, strategies that will have a significant impact on our premiums remain elusive. For the past several years Summit County Health Care Collaborative via a small working group consisting of partners from Summit County Government, Centura Health System, the Summit Community Care Clinic, the Family and Intercultural Resource Center and the Summit Foundation, with input from other entities as appropriate (Including Rocky Mountain Health Plans) have been working to identify locally driven short term and long term strategies. As part of the development of our long term strategies we would like to analyze our claims data and data from self-funded employer sponsored plans (not currently captured within APCD data) to address two potential factors which may be driving costs, first, the impact of our large employer self-funded insurance population on our overall costs, and secondly, what are the true cost drivers of our health care costs and how those deviate from other communities, for example those on the front range. Having this data, we can then work locally to design programs which will help address those cost drivers. In addition to accessing APCD data, we will also work to add claims data from our self-funded insurance plans. Please note they are working in conjunction with the RCCO as part of the collaborative.
TOTAL		**$217,328**	

JBC Staff FY 2018-19 Figure Setting Department of Health Care Policy and Financing

(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, and Other Medical Programs)

Presented by:
Eric Kurtz, JBC Staff

March 5, 2018

Agencies Included in Staff Figure Setting Document

Executive Director's Office
(Page 37)

Medical Services Premiums
(Page 68)

Indigent Care Program
(Page 78)

Other Medical Services
(Page 86)

Overview

Staff Recommendation

$8,716.6 million total funds
$2,344.1 million General Fund
449.1 FTE

Department Request

$8,916.8 million total funds
$2,377.6 million General Fund
454.7 FTE

2 Staff-initiated Changes

26 Department Requested Changes

28 Department and Staff Decision Items

(includes decision items, budget amendments, and staff-initiated changes)

Decision Items Affecting Multiple Divisions (p6)

- R6 Home care visit verification (p6)
- R7 Community transition services (p9)
- R8 Medicaid savings initiatives (p12)
- R9 Provider rates (p19)
- R10 Drug cost containment initiatives (p24)
- R12 Children's habilitation transfer (p25)
- R14 Safety net programs (p26)
- R15 CHASE administration (p29)
- R16 Emergency transport CPE (p33)
- R17 Single assessment tool (p35)

(1) Executive Director's Office (p37)

- HAS administrative costs (p38)
- R11 Administrative contracts (p39)
- R13 All-payer Claims Database (p39)
- R18 Cost allocation (p45)
- R19 IDD waiver consolidation (p46)
- BA11 County administration (p46)
- BA14 Benefits utilization system (p46)
- NP CBMS-PEAK, NP OIT HCPF security, NP Risk management cybersecurity (p47)
- Staff Initiated – Transfers Local Public Health Agencies (p47)
- Staff Initiated – Veterans outreach (p48)

(2) Medical Services Premiums (p68)

Change Requests

- R1 Medical Services Premiums (p69)

Line Items, Base Appropriations, and Other Changes

- (2) Medical Services Premiums (p68-77)

(5) Indigent Care Program (p78)

Change Requests

- R3 Children's Basic Health Plan (p78)

Line Items, Base Appropriations, and Other Changes

- (5) Indigent Care Program (p78-85)

(6) Other Medical Services (p86)

Change Requests

- R4 Medicare Modernization Act (p86)
- BA12 Public School Health Services (p89)
- NP Family medicine residencies (p90)

Line Items, Base Appropriations, and Other Changes

- (6) Other Medical Services (p86-96)

Long Bill Footnotes and RFIs (p97)

Long Bill Footnotes

- 7 Recommendations (p97)

Requests for Information

- 3 Recommendations (p99)

JBC Staff FY 2018-19 Figure Setting Department of Health Care Policy and Financing

(Executive Director's Office, Medical Services Premiums, Indigent Care Programs, and Other Medical Programs)

Presented by:
Eric Kurtz, JBC Staff

March 5, 2018